The Handbook of Person-Centred Psychotherapy & Counselling

Mick Cooper, et al.

Second Edition

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The Handbook of Person-Centred Psychotherapy & Counselling

Second Edition

palgrave
macmillan

First edition 2007
Second edition 2013

Published by
PALGRAVE MACMILLAN

Palgrave Macmillan in the UK is an imprint of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire RG21 6XS.

Palgrave Macmillan in the US is a division of St Martin's Press LLC, 175 Fifth Avenue, New York, NY 10010.

Palgrave Macmillan is the global academic imprint of the above companies and has companies and representatives throughout the world.

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ISBN: 978–0–230–28049–6

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources. Logging, pulping and manufacturing processes are expected to conform to the environmental regulations of the country of origin.

A catalogue record for this book is available from the British Library.

A catalog record for this book is available from the Library of Congress.

10 9 8 7 6 5 4 3 2 1
22 21 20 19 18 17 16 15 14 13

Printed in China

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Dorothy T. Fleck, MS, was a licensed marriage and family therapist and a clinical supervisor for over nine years at South Bay Community Services in Chula Vista, California, USA, until her untimely death on 3rd October 2012. She was an expert in the treatment of addictive disorders, relational violence, child and adolescent issues, couples therapy and the training and supervision of marriage and family therapist interns. Dorothy collaborated with her husband, J. Roland Fleck, on a number of presentations on person-centred approaches for the treatment of addictive disorders and relational violence.

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Pete Sanders spent over 30 years practising as a counsellor, educator and clinical supervisor, retiring from practice in 2003. He has written, co-written and edited books, chapters and papers

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Richard Worsley has worked as a priest, a counsellor trainer and now a university counsellor. He has published books and articles on process orientation and on the philosophy and spirituality of therapy. Richard has an abiding interest in the work of Martin Buber and Emmanuel Levinas. Being with staff and students is crucial for him to reflect on practice and the therapeutic relationship.

Gill Wyatt is the director of Creating Synergies, a facilitation, research and consultancy service for individuals, organizations and communities. She has been involved with the person-centred approach for over 25 years as a psychotherapist and by managing/tutoring on postgraduate and graduate courses. Her work and research currently involves 'cultural therapeutics' – engaging with the complexity of the challenges facing us in the twenty-first century to facilitate societal transformational processes.

Preface

It is with great pleasure that we welcome you to this, the second edition, of *The Handbook of Person-Centred Psychotherapy and Counselling*. The first edition of our text, published in 2007, was warmly received by the person-centred community. In this new edition, we hope to build on these foundations, respond to feedback from readers and reviewers, and produce an ever more comprehensive, authoritative and contemporary critical review of person-centred theory and practice.

Revisions for this second edition of the text include:

- A new, introductory chapter (Cooper et al.) looking at contemporary challenges and opportunities for growth for the person-centred world.
- Nine further new chapters: spiritual dimensions of the person-centred approach (Van Kalmthout); presence (Geller); creative practices (Natalie Rogers); person-centred therapy and integration (Cain); assessment and formulation in the person-centred approach (Gillon); and person-centred work with children and young people (Behr et al.), older people (Washburn), the bereaved (Larson) and people with addictions (Fleck and Fleck).
- Increased use of text features – such as boxes, bullet lists, part introductions, points for reflection and key readings – to make the chapters more accessible and engaging.
- A greater focus on actual practice, with more case studies and examples of therapist–client dialogues.
- Increased reference to research.
- A general updating of all chapters to include all relevant post-2007 references.
- A greater emphasis on the *radical* nature of the person-centred approach: de-pathologizing, *client*-centred, potentiality-focused, counter to the established diagnostic-based medical model, and political.

For this second edition of the Handbook, we have also taken the opportunity to reorganize and reorientate some of the chapters from our first edition: client incongruence (Warner), Pre-Therapy (Van Werde and Prouty) and applications beyond the therapeutic context (Henderson et al.). In addition, six chapters from our first edition were not included in this updated text: an introduction to person-centred therapy (Sanders); the relational foundations of person-centred practice (Barrett-

Lennard); client perception (Toukmanian and Hakim); the process of person-centred therapy (van Kalmthout); person-centred therapy within a medical framework (Finke and Teusch); and training (Tudor). This decision does not, in any way, reflect on the quality of these chapters – each of which we consider very valuable contributions to the field – but was part of an attempt to create a more coherent and focused overall text within the word limit available.

For this edition, we are delighted to welcome Art Bohart into the editorial team. Art is one of the great voices within the person-centred world and is particularly well known for his work on clients as active agents of change.

At the same time, we would like to take this opportunity to say 'goodbye' to Gill Wyatt as a co-editor of the Handbook, and to thank her for all her work on the first edition of this text. Gill was an enormously important driving force in bringing the first edition to fruition, and her contribution lives on throughout many different parts of this updated text.

About the Handbook

The Handbook of Person-Centred Counselling and Psychotherapy was developed as a comprehensive, cutting-edge resource for students on all advanced level person-centred courses, as well as for a wide range of professional practitioners in the field. Furthermore, as an inclusive and state-of-the-art summary of the person-centred approach, we hope it will continue to serve as a focus for many further developments.

Contributors to this book come from a diversity of positions within the person-centred field. We have chapters, for instance, from those who are affiliated to a *classical* model of client-centred therapy (for example Bozarth and Freire); those at the forefront of an *encounter*, *dialogical* or *interpersonal* orientation (for example Barrett-Lennard, Cooper and Schmid); those who stress *organismic* and *holistic* thinking (such as Cornelius-White and Wyatt); those developing creative ways of clinical work and theory (for example Warner and Rogers); and those leading the way in the development of Pre-Therapy (for instance Van Werde). While contributors from each of these positions present somewhat different perspectives on the theory and practice of person-centred therapy, we see this diversity as a great strength of both the field and the book. Having said that, the editors of this book are particularly orientated towards a more relational, ethics-based reading of person-centred theory and practice, with a particular focus on clients as active agents of change, and these 'biases' may be evident as the book unfolds.

One of the most important dimensions of this handbook is its internationality and interdisciplinarity. This follows from our understanding of the person-centred approach: that by embracing plurality and diversity we gain a much better picture of the human being and the therapeutic endeavour. Besides the UK, our authors come from a wide variety of countries, language groups and backgrounds. Their work represents diverse philosophical, psychological, scientific, medical, sociological, empirical and clinical perspectives.

With respect to the issue of diversity within person-centred therapy, we should also say something of what has *not* been included in this handbook. Within the field of humanistic therapy, one of the most exciting developments over the last few decades has been the *experiential* therapies: in particular, focusing-oriented therapy and process-experiential/emotion-focused therapy. These therapies have emerged from, and are closely aligned with, the person-centred approach, even though we feel there are differences regarding the foundations, the theory and the practice. A great deal of collaboration has taken place with these two fields, not least the World Association for Person Centred and Experiential Psychotherapy and Counseling (WAPCEPC) and the journal of *Person-Centered and Experiential Psychotherapies*. Nevertheless, for the purposes of this Handbook, we have not attempted to cover, in depth, the field of experiential therapies, although it is touched on in several places. This is primarily because it would be impossible to do it justice in the space, and also because an excellent handbook of experiential therapies already exists (Greenberg et al.'s *Handbook of Experiential Psychotherapy*, London: Guilford Press, 1998).

With respect to the format of this Handbook and its chapters, we have attempted to achieve a balance between the coherence of a consistently structured text and the creativity and individuality that a less formal structure allows. In this respect, readers will note some variations in the style, emphasis and structure of our contributions. Throughout each chapter in this book, however, readers will find a comprehensive and critical exploration of the aspect of person-centred therapy under discussion, one that points readers to further sources by which to expand their knowledge and practice. Here, the core principles at the heart of this Handbook are those of critical openness and inclusivity – to the range of ideas and developments within the person-centred field, to the limitations and challenges of our approach, and to the potentialities that exist to help us take this field forward. For us as editors, such principles must be at the heart of this Handbook, for we see them as the very essence of what it means to be person-centred.

This book begins with a short chapter introducing some of the challenges facing the person-centred world today, and how it can develop and expand through meeting these opportunities for growth. This is followed by an introductory piece by Carl Rogers – unpublished in the English language except for the previous edition of this book – which is a condensed version of a talk given to psychotherapists at the Medical Faculty of the University of Vienna, Austria, on the 2nd April 1981. In this introductory piece, readers can learn how Carl Rogers introduced person-centred therapy to colleagues from other orientations.

The book is then divided into four parts, with a brief introduction at the beginning of each part to give an overview of its chapters. The first part of the book looks at the theoretical, philosophical and historical foundations of the person-centred approach. The second part builds on this by examining the fundamental principles of person-centred practice, critically examining Rogers' necessary and sufficient conditions for therapeutic personality change, as well as new developments in, and applications of, person-centred practice. The third part of the book looks at how

person-centred conceptualizations and practices can be applied to groups of clients who bring particular issues to therapy, such as bereavement or difficult processes. Finally, the book considers professional issues for person-centred therapists, such as ethics, supervision and training. Material featured in text boxes is differentiated by a tint according to whether it is factual or illustrative.

As editors, we hope that this book will provide readers with an integrated, comprehensive understanding of the contemporary person-centred field, in all its creativity, diversity and depth. More than anything, though, we hope this book will motivate readers to develop and further their own theory and practice, and in doing so to take the field forward in ever more innovative and exciting ways.

For the purposes of anonymization, details of clients have been changed and disguised throughout this book.

The editors are particularly grateful to Catherine Gray, Esther Croom, India Annette-Woodgate and the team at Palgrave for all their support and encouragement in the production of the book and to Carrie Walker, Julie Lankester, Linda Norris, and the team at Aardvark Editorial for their fantastic work on the copy-editing, proofing and layout of the text. Chapter 2, Rogers' introduction to the basic conditions of the facilitative therapeutic relationship was transcribed by Aglaja Przyborski and Peter Frenzel, and titled and abridged by Peter F. Schmid (first published in German translation in Frenzel, Schmid and Winkler, *Handbuch der Personzentrierten Psychotherapie*, Cologne: Edition Humanistische Psychologie, 1992). Thanks to Carolyn Bryce, Print Services, University of Strathclyde, for her help with Figure 8.1. Finally, the editors would like to thank all the contributors to this Handbook – past and present – for their enthusiasm, commitment and creativity in helping this project to grow and evolve.

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1

Person-centred therapy today and tomorrow: vision, challenge and growth

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This chapter discusses:

- A person-centred vision for counselling, psychotherapy and social change
- The key contemporary challenges facing the person-centred approach
- Meeting the challenges through developing the evidence base for person-centred counselling and psychotherapy
- Meeting the challenges through articulating, and developing, the unique contributions of the person-centred approach
- Meeting the challenges through developing our understanding of different client groups; developing our political acumen and links both internationally and with other approaches; using person-centred principles as the basis for integrative theory and practice; and extending person-centred concepts into the sociopolitical realm

Person-centred counselling and psychotherapy offers a radically non-pathologizing, evidence-based, humanistic vision of how to help people heal and grow. It is unique among current therapies in focusing on the potential of all human beings to self-right, actualize themselves, become more fully human and develop their capacities for a deep caring of others. Person-centred therapy offers a major alternative to approaches that – while often helpful and well-meaning – tend to

see people through the lens of disease, reducing them to their dysfunctional cognitions, conditioned responses or instinctual drives. Of most importance to the person-centred approach is its vision of the nature of the human being and its focus on the power of an empathic, supportive relationship for facilitating personal and social transformation. This goes right back to the very foundations of the approach, where Carl Rogers' outlined the basic conditions of a facilitative therapeutic relationship (see Chapters 2 and 3).

Person-centred therapy has historically has been one of the most influential approaches in the field of psychological therapies. Its founder, Carl Rogers, is still seen as the single most influential psychotherapist by other psychotherapists, even over Freud (Cook, Biyanova, & Coyne, 2009). Some of its tenets, for instance on the importance of the therapeutic relationship, have been widely adopted by other therapeutic approaches and research programmes (see, for instance, Norcross & Lambert, 2011).

Yet, despite the evidence that person-centred therapeutic approaches have levels of effectiveness equivalent to those of other therapies (see Chapter 31), the full vision of the person-centred approach – with its focus on the positive self-determined growth potential of human beings – has, in the current healthcare environment in many countries, come to be overshadowed by approaches that focus on the engineering of how people think, feel and behave (Box 1.1). In an age when human dignity seems to be under assault from a reduction of human beings to the status of objects and mechanisms – and where mental distress is on the rise globally – approaches to health and growth that affirm the human capacity for self-regulation and healing, and that are aligned with the emergent creative impulse in all living systems, would seem to be needed more than ever.

Box 1.1

The person-centred approach within late modernity

In some parts of the world, the person-centred approach appears to be losing ground, outrun by approaches such as cognitive-behavioural therapy (CBT) and psychopharmacology that are framed within an instrumentalist and mechanistic worldview. This can be seen as being consistent with – and reflecting – the cultural crisis of late modernity wherein dimensions of life once understood through the multiple frames of politics, morality, civil society, religion, culture and the arts tend to be squeezed into the shrunken logic of economics and technology. To understand the success of such approaches in the last decades requires that we understand the existential crisis of late twentieth- and early twenty-first-century consumer societies.

Largely as a consequence of the success of twentieth-century science and industrialized capitalism to deliver what once needed communities to provide, the

predominant sense of ourselves, what Fromm (1955) called our *social character*, has started to lose contact with a deeper flow of human existence, with our connection to each other, and with our dependence upon the natural world. So, in compensation perhaps, most of our attention is on control and manipulation – of ourselves as isolated and vulnerable individuals and of the inevitabilities of illness and death – and on an exploitation of our environment as means to gratify our endlessly manufactured and so insatiable appetites. The emancipatory project of humanistic psychology, especially person-centred approaches, has been to address this alienation, to re-connect people to a universal creative force, and to restore the freedom and dignity of each person to become fully human in relationships.

Neither CBT nor psychopharmacology is necessarily antagonistic to the search for transcendence that animates humanistic approaches. Indeed, many humanistic psychologists, even person-centred therapists, use the empowering and healing potential of both in their work. But whether a psychotherapeutic process is emancipatory or manipulative depends largely on the philosophical, ethical, societal and institutional framework within which it is offered, and it must be admitted that both CBT and medications have become part of a medical industrial complex that is often vastly profitable. The mental health world, then, can be seen as being engaged in its own version of the larger cultural crisis that shows up in the increasingly acrimonious debate between those who see mental health interventions through a mechanistic lens of industrialized medicine, and those who see counselling and psychotherapy as a path to greater capacity for self-determination and wholeness.

Challenges

In many parts of the world, for instance Austria, Eastern Europe, South America and China, the person-centred approach continues to thrive and grow. In other regions, however, person-centred therapists have struggled to maintain and develop their identity and viability, particularly within the contemporary healthcare landscape (Cornforth & Lambers, 2010). In the UK, for example, publicly funded person-centred therapy services are being decommissioned, and members of the person-centred community state that they feel that their profession, orientation and employment are under threat (Cooper, 2011) (for a further discussion, see Chapter 26). In Germany, meanwhile, Hofmeister (2010, p. 7) reports that the person-centred approach is 'gradually and increasingly disappearing from sight' in the field of psychotherapy, the approach being marginalized within academic institutions, and person-centred therapists only being able to be licensed within the system of health insurance companies 'under the accepted labels of "psychodynamic" or "(cognitive) behavior therapy'. Even in Japan, which has an otherwise thriving person-centred

and person-focusing community, Shimizu (2010) reports pessimism over the future of the person-centred approach, and that young trainee and practising therapists are being attracted towards cognitive-behavioural therapy (CBT).

The rise of the empirically supported therapies movement

These shifting fortunes may to a great extent be attributed to the changing landscape for psychotherapy and counselling services in general. As healthcare costs rise exponentially everywhere, anxious to meet public pressure for value for money, there has been a global movement calling for more accountability in all service sectors. This has driven a rising demand for the so-called empirically supported therapies (ESTs). Healthcare is a highly contentious space, with immense political and economic forces at play. This is particularly true in advanced technological societies such as Northern Europe and Japan, where economic logic, closely coupled with mechanistic science, is the taken-for-granted way of understanding effectiveness.

The basic principle behind the EST movement is that therapeutic practices are considered valid only to the extent that they have been 'proven' to work: through experimental studies (primarily randomized clinical trials [RCTs]), with particular groups of clients, with specific diagnoses (see Chapter 31). This is the viewpoint held by many powerful political organizations, such as England's National Institute for Health and Clinical Excellence, whose recommendations on clinical treatments for specific psychological difficulties has directly informed the commissioning and funding of publicly available therapeutic services and training, most notably through the recent Improving Access to Psychological Therapies programme.

Here, the problem for person-centred therapies is *not* that they have been proved ineffective or inefficient. Rather, in contrast to other orientations such as CBT, there have simply not been enough of the kinds of study that organizations like the National Institute for Health and Clinical Excellence endorse to *prove* their efficacy. And the reason for this touches a principled question: to a great extent, the research methods employed in these studies violate the fundamental beliefs and practices of person-centred theory and practice. An RCT, for instance, requires a categorization of clients into specific diagnostic groupings, random allocation to different 'conditions', the delivery of standardized, 'manualized' therapies, and an analysis of data that reduces clients' lived-experiences down to de-contextualized, de-individualized averages (see Chapter 31 for a further discussion).

Members of the person-centred and counselling communities (see, for example, Cooper, 2008; Rowland, 2007), along with many other psychotherapy researchers and academics (for example, Wampold, 2001; Westen, Novotny, & Thompson-Brenner, 2004), have vigorously challenged the assumptions underlying ESTs. They have highlighted, for instance, the lack of evidence for the existence of discrete psychological 'pathologies', the way in which RCTs can be biased in favour of the researchers' own allegiances, and the overwhelming body of evidence to suggest that it may not be therapeutic orientation that determines the outcome, but such *common*

factors as the quality of the therapeutic relationship and clients' levels of motivation. Nevertheless, all the evidence indicates that the EST movement is carrying on unabated (Cooper, 2011). It seems unlikely, then, that the challenge of the EST movement will decline in the near future, and the ability of the person-centred movement to respond constructively to it may be a key determinant of its ability to flourish in many regions of the world.

Dilution of person-centred values and practices in integrationism and eclecticism

Although almost all therapeutic approaches refer to person-centred principles – such as empathy, prizing the client's own valuing system, attentiveness, authenticity and non-intrusiveness (mainly without referencing the Rogerian origins of such thinking) – most of them see these characteristic as ingredients that need *to be used* in therapy *in order to* make therapy work. This means that, on the one hand, the person-centred approach is having a major impact on the development of psychotherapy as such; on the other hand, however, this can water down the very gist and essence of the core idea of the person-centred approach, namely that it is engagement within the relationship that *is* the therapy (see Chapter 5 and Part II).

Developments that come from within the approach also present a challenge. There are attempts to combine the person-centred approach with techniques from other orientations, regardless of ethical considerations and reflections on the image of the human being, often in the attitude of 'anything goes' or 'anything that is "positive" helps', or even 'whatever I do for the client is "client-centred"'. But the logic here seems to follow the idea that 'chocolate sauce is fine, fish is fine … so fish with chocolate sauce must be twice as tasty!' Such haphazard, uncritical and unsystematic combinations of theories and practices (Hollanders, 2003) run the risk of reducing the person-centred approach to a *syncretic* mish-mash of practices: a bland, superficial eclecticism. This is not to say that all integrations or hybridizations are theoretically incoherent and clinically ineffective. In fact, a value-based integrative practice is suggested later in the chapter as one possibility for developing the person-centred approach (see also Chapter 17). But the key to these latter forms of integration is that they root themselves in person-centred anthropology and values (see Chapters 5 and 6). The ability to know the difference between an incoherent mash-up and a potentially creative synergy requires critical discernment.

Global social, environmental and economic threat

Alongside challenges from within the therapy world, it should not be forgotten that the twenty-first century will present humanity with challenges that will threaten entire ecosystems and perhaps the survival of civilizations (see Chapter 32). Already there are signs that the constellation of pressures from escalating economic instability, war, famine, population dislocation, global climate change and scarcities of

energy, food, water and other vital resources – coupled with the disintegration of cultural coherence and continuity – are producing a serious deterioration in mental health on a global scale. By 2020, depression is expected to be the second leading cause of death after heart disease, and most of it goes untreated (O'Hara, 2010). Population-scale mental distress may need approaches to care that de-emphasize individual counselling in whatever form in favour of health promotion, personal empowerment, re-personalization, medication and capacity-building within communities to train local people to care for people where they live.

Meeting the challenges

How, then, have – and can – members of the person-centred community meet these challenges? First and foremost, perhaps, person-centred practitioners, theoreticians and researchers need to remember and recall the strengths inherent in their approach to fellow human beings. From its foundation, the person-centred approach has been an approach that leaves the power with the client (whence it is *client-centred*) and regards individuals as people fully capable of living their own lives, when encountered and supported by another person (whence it is *person-centred*). It regards psychotherapy as an emancipatory practice, and as such it is primarily concerned with people becoming more fully human in their own way.

The person-centred approach trusts in facilitating this process of personality development through a dialogical relationship (see Chapters 2 and 5). Among the strengths of the approach are its anthropology (see Chapter 5), its ethically and empirically based exploration of the nature of the human being (see Chapters 28 and 31), its openness to non-orthodoxy, its commitment to development and thus research (see below), its principled scepticism towards categorizations (traditional diagnostic systems) and dogmatism (schoolism), and – intrinsically connected – its attentiveness to societal and political processes (see Chapter 32). Person-centred approach thinkers have also been at the forefront of establishing psychotherapy science as a discipline in its own right (for example, person-centred psychotherapy science as an independent study at the Carl Rogers Institute of the Sigmund Freud University in Vienna) instead of seeing it as an appendix to psychiatry or psychology.

Consolidating and developing the person-centred evidence base

One of the main legacies of Carl Rogers to the field of psychotherapy was rigorous empirical research. Although the methods of Rogers and the person-centred approach in conceptualizing – and carrying out research – can be very different from those of the mainstream (see below and Chapter 31), research has been willing to meet the challenge of the current trend to prioritize ESTs.

In this respect, one emerging response to the call for ESTs has been to develop, or bring to the fore, the evidence that already exists for person-centred therapies. Robert Elliott has for several years advocated and led such a strategy (Elliott, 2002a,

2002b; Elliott & Freire, 2008, 2010; Elliott & Greenberg, 2002; see also Chapter 31), and in the closely related field of the experiential therapies (see, for example, Elliott, Greenberg, & Lietaer, 2004; Greenberg & Dompierre, 1981; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), it has proved relatively successful and has led to the establishment of emotion-focused therapy, also known as process-experiential therapy, as an evidence-based treatment for depression by the American Psychological Association (see www.div12.org/treatments).

With such a strategy in mind, at the 2008 conference of the World Association for Person Centered and Experiential Psychotherapy and Counseling (WAPCEPC) in Norwich, a Task Force was set up to 'review the evidence-base for PCE [person-centred and experiential] practice, to disseminate the results of this investigation, and also to identify key areas in which the evidence base for PCE practice needs to be developed.' The product of this enterprise, *Person-centred and Experiential Therapies Work: A Review of the Research on Counseling, Psychotherapy and Related Practices*, was published in 2010 (Cooper, Watson, & Hölldampf, 2010b), and provides the first comprehensive summary of evidence for PCE approaches, as well as a review of person-centred methods of research and person-centred measures.

Such a review of the research is in itself, however, unlikely to have much of an impact on EST-oriented commissioning and funding bodies. For although much RCT research can be reviewed and analysed to point towards the effectiveness of person-centred practice (see Chapter 31), it is often not of the 'right type', lacking a focus on specific clinical disorders, with poorly defined 'interventions' and inadequate methodological rigour. On this basis, the editors of *Person-centered and Experiential Therapies Work* (Cooper, Watson, & Hölldampf, 2010a) argue that there is a need for members of the person-centred community to adopt a pragmatic stance, writing that:

> a key priority for research in the PCE field – both psychotherapeutic and non-psychotherapeutic – must be to conduct randomised controlled trials of a type that have the potential to impact upon policy-makers (see, for example, Watson et al. (2003) or King et al. (2000)). Such trials will need to:
>
> - Focus on a specific group of clients, such as clients meeting criteria for generalised anxiety disorder or major depression;
> - Be conducted and written-up according to standardised recommendations for high quality trials (see Moher, Schulz, & Altman, 2001);
> - Use a standardised PCE intervention.

In developing the evidence base for person-centred therapies, however, it would seem important not just to focus on RCT methods, and Cooper et al. (2010a) go on to recommend several other strategies through which the evidence base might be enhanced:

- Systematically drawing together research findings in the person-centred field through quantitative (for example, Bratton, Ray, Rhine, & Jones, 2005) and qualitative (for example, Timulak & Creaner, 2010) *meta-analyses*.

- Conducting *process research* with individual cases or sets of cases to help identify the helpful (and unhelpful) aspects of person-centred therapy (see Watson, Greenberg, & Lietaer, 2010).
- Qualitative and quantitative explorations of phenomena that emerge from a person-centred understanding of human being and change, such as *presence* (see Chapters 5 and 14) and *relational depth* (see Knox, Murphy, Wiggins, & Cooper, 2013).
- Developing measures, like the Authenticity Scale (Wood, Linley, Maltby, Baliousis, & Joseph, 2008) and the Strathclyde Inventory (Freire, Cooper, & Elliott, 2007), which can directly assess the outcomes and processes associated with person-centred theory and practice.
- Using research findings to help improve the effectiveness of, and/or client experience within, person-centred therapy (for example, Greenberg, 1979, 1980).
- Developing methods of research that are specifically consistent with person-centred theory and practice, such as phenomenological inquiry (see Wilkins, 2010).
- Developing and conducting case studies (see McLeod, 2010).

In addition, a very valuable emerging strategy for the person-centred field may be:

- Collecting, collating and reporting practice-based evidence, using tools such as the CORE-OM (Barkham et al., 2001), which can indicate the extent to which person-centred practice, in 'real-world' settings, is associated with reductions in psychological distress (for an excellent example, see Gibbard & Hanley, 2008).

Cooper et al. (2010a) also give concrete suggestions for how each member of the person-centred community can contribute to developing the evidence base, making the point that there is no one 'out there' – or even within the community – that can do this work for us: that it is a responsibility for us all (Box 1.2).

Box 1.2

Developing the evidence base for person-centred therapy: what you can do

Academics/researchers/research students

- In choosing a subject to research, always consider the likely policy impact – ask yourself, 'Is this going to contribute to the development of the person-centred and experiential (PCE) approach?'
- Design, and apply for funding for, a pilot randomised controlled trial of PCE therapies with a particular client group.
- Set up, help to collect, and/or analyse person-centred PBE [practice-based evidence].
- Conduct a meta-analysis of PCE therapy with a particular client group.

- Develop a study which can help to validate a PCE outcome measure.
- Develop an outcome or process measure that assesses a particular aspect of PCE theory or practice.
- Consider how you can use research to help you develop PCE practices.
- Publish a case study of PCE practice.
- Engage in PCE research.
- Develop rigorous and systematic critiques of positivistic research methods.

Practitioners and non-research students

- Link up with others in the field who are interested in developing evidence for the approach (for instance, the British Association for the Person-Centred Approach (BAPCA) now has a Research Group, email: research@bapca.org.uk [see also www.bapca.org.uk/research.html]), and see how you might get involved.
- Evaluate your work using outcome measures (such as CORE-OM) at pre- and post-counselling, or process measures like the Experiencing Scale (Klein, Mathieu-Coughlan, Gendlin, & Kiesler, 1969).
- Familiarise yourself with the research findings for PCE and other therapies, as well as the critiques of 'evidence-based' assumptions (see, for instance, Cooper, 2008; Cooper, Watson, & Hölldampf, 2010b; Elliott, et al., 2004).
- Consider enrolling for a research (MA/MSc/PhD) programme.
- Contact PCE-oriented researchers/academic to see how you can collaborate on research.
- Consider writing a case study (see McLeod, 2010).

(Cooper et al., 2010a, p. 294)

The drive to consolidate, articulate and develop the person-centred evidence base may seem like a primarily defensive measure, designed to ensure the long-term survival of person-centred therapy. Yet to the extent that research, as identified above, can help the person-centred community to refine, develop and enhance its practice and theory (as an excellent example, see Geller's work on presence in Chapter 14), it also provides an opportunity for growth.

One emerging finding from studies of clients' experiences of therapy, for instance, has been that feeling genuinely *cared for* is a key element of successful therapy (McMillan & McLeod, 2006) and it may be that, in the coming years, we will come to see *care* as a better articulation of a necessary and sufficient condition for therapeutic personality change than *unconditional positive regard*. In this respect, the current research agenda has the possibility of helping the person-centred approach go back to – and build on – its roots in the 1940s and 50s: as a vibrant and inquiring community of practitioners, researchers and academics who draw extensively from the research evidence – indeed who, at their time, led the psycho-

therapy research field (McLeod, 2002). This attitude towards research is summed up by Carl Rogers himself (1986, cited in Cain, 2010, p. 42), stating:

> There is only one way in which a person-centred approach can avoid becoming narrow, dogmatic and restrictive. That is through studies – simultaneously hard-headed and tender-minded – which open new vistas, bring new insights, challenge our hypotheses, enrich our theory, expand our knowledge, and involve us more deeply in an understanding of the phenomena of human change.

Articulating, and developing, the particular contributions of the person-centred approach

With current movements towards a greater integration of therapies – as well as the counter-movement towards ESTs – the future of the person-centred approach may also be dependent on its ability to articulate, and emphasize, its particular contribution to the wider therapeutic field. If moves towards a greater integrationism are considered inevitable, however, or even embraced (see Chapter 17 and below), another way of phrasing this question might be to ask: 'How can we ensure that the key values and practices of person-centred therapy become embedded, in meaningful and significant ways, in a broader landscape of growing integrative and eclectic practices?' Moreover, how can we work towards developing, and building upon, these particular contributions, so that they continue to remain a figural, vibrant and thriving element of this wider therapeutic field?

In recent years, numerous members of the person-centred community have been working on articulating what these particular contributions may be, and each of these can serve as valuable foundations for future work.

A humanizing commitment

For many of us, the heart of a person-centred approach is the commitment to engaging with clients in 'deeply valuing and respectful ways' (Cooper, 2007, p. 11). Therapeutic techniques, strategies and theories may all have their place in an integrative landscape, but a person-centred perspective keeps to the fore the ethical responsibility to engage with each client as a growth-oriented, subjectively experiencing Other (see Chapter 28), and not as a mechanism, thing or collection of bit-parts that requires external 'fixing'. Such a basic, humanizing, stance has acted as the basis for several important person-centred contributions in recent years, such as Warner's reconceptualization of psycho-'pathology' as *difficult processes* (see Chapter 23), and has the potential to underpin many more humanizing ways of understanding clients and the therapeutic process.

Deep relating

The concept of a *therapeutic*, or *working*, alliance has become common currency across the psychotherapies (see, for instance, Hovarth, Del Re, Fluckinger, & Symonds, 2011), but where person-centred (and again related humanistic and existential)

approaches make a particular contribution is their emphasis on a depth, intensity and genuineness of relating (see Chapter 5). Here, the relationship is not merely the crucible in which the therapeutic work is held and made safe; rather, the relationship *is* the therapy, and it is through a deep and enduring level of connectedness with the therapist that the client is seen as being able to come to re-connect with self and others.

One of the most prominent attempts to articulate, and develop, this unique aspect of person-centred therapy is Mearns and Cooper's (2005) work on *relational depth*. This is defined as 'A state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level' (p. xii). Unusually, perhaps, for the person-centred field, the concept of relational depth has stimulated an ongoing programme of empirical research (see Knox et al., 2013), with investigations into clients' experiences of in-depth relating in therapy (see, for example, Knox, 2008), and the development of a relational depth inventory (Wiggins, Elliott, & Cooper, 2012). Closely connected to this work, Peter F. Schmid has continued to develop his philosophical and anthropological investigations into the meaning of dialogue and encounter as the heart of person-centred practice (Schmid, 2009; see also Chapter 5), with other leading figures in the person-centred field, such as Godfrey Barrett-Lennard (2005), also working on the development of relational theories and practices (see Chapter 8).

A non-directive stance

Not all members of the person-centred community agree that non-directivity is the *sine qua non* of person-centred practice (see Chapter 17), yet it is perhaps its most unique contribution, and an ability to be appropriately non-directive has been recognized as a common element of effective therapy within a much broader psychotherapy research field (Castonguay & Beutler, 2006). In recent years, members of the person-centred community have also worked to further articulate and develop this concept (Levitt, 2005) and to explore its relationship to the actualizing tendency (Levitt, 2008), emphasizing that non-directivity is not just one 'technique' among many but a fundamental attitude and principled stance (Grant, 2002, 2004) that is building on a conviction of autonomy, self-determination and emancipation.

The importance of self-concordance to wellbeing

Cognitive-behavioural, psychodynamic, narrative and other therapeutic approaches may tell us much about the causes and correlates of psychological wellbeing, but only person-centred (and related humanistic and existential) approaches articulate the importance of being 'true to ourselves' or *self-concordant* (Sheldon, 2001) – that is, of acting in ways that are consistent with our most deeply held values, purposes and preferences (Box 1.3; see also Chapter 8). Concomitantly, it is only the person-centred and related field that helps us understand how psychological distress can emerge from an alienation or estrangement from our basic experiencing, and Stephen Joseph and Richard Worsley (2005) have led some important developments here.

Box 1.3

Coming to be me: Irena's journey

'I just have no idea who I am,' said Irena, a slight, pale young Polish woman in her second session of therapy. Irena had come to therapy to try to deal with her feelings of overwhelming anxiety – particularly in social situations, where she felt acutely judged by others – and to try to understand where her unhappiness, pessimism and feelings of detachment in life had come from.

Irena had been brought up in a family of business people who had pushed her towards academic and social successes. 'When I came back with nine out of ten on a test,' said Irena, 'my dad would ask me why I didn't get ten.' From her mother, and through her private education in Switzerland, Irena had also learnt that she should be a 'proper young lady', someone who was 'prim and proper', content with life, who kept her emotions (particularly anger) in check and obtained her pleasure from caring for others. 'A bit like a Stepford Wife', she reflected.

Irena smiled warmly when she arrived for session eight. She then proceeded to describe how awful she had felt that week. For the first time, her therapist noticed how different her presentation could be from how she actually felt. He fed that back to her, and they began to talk about the 'two Irenas': the person she showed to others and the 'real person' that she was underneath.

Who was this real Irena? From what had emerged in the therapy so far, she was clearly someone who was far from emotionless but was enormously passionate and who cared deeply about her world and others. And when asked about what she really liked doing, Irena talked about how much she loved being playful and silly, and how her greatest passion was actually watching videos of 'street dancing' (not ladylike at all!). The next session, Irena also admitted – both to herself and to her therapist – that, actually, she really did not like spending much time with the people she felt so acutely judged by. 'I think I just get bored by them, particularly in groups,' she said, and she talked about the way that she would much prefer to be spending one-to-one time with close friends.

In the therapeutic work with Irena, a critical element was helping her develop a sense of who she really was and what she actually liked and did not like in life – without that, as Irena acknowledged, her chances of moving forward were slight. And while non-humanistic therapies, such as CBT, may have much to say about the development and alleviation of psychological distress, they are not able to account for, or conceptualize, the distress that clients like Irena experience as a result of self-alienation. Hence, person-centred and humanistic approaches have a unique contribution to make here: helping the wider therapeutic field to see the value, to many clients, of living in accord with their true values and preferences.

An understanding of the client as an active agent of change

Bohart and Tallman (1999), leading figures in the person-centred field, have been instrumental in developing an understanding of therapeutic change that is fundamentally rooted in client activity and agency (see Chapter 6). Their 1999 text, *How Clients Make Therapy Work: The Process of Active Self-healing*, drew extensively from research, theory and practice to demonstrate how it is the client, and not the therapist, who is the main driving force behind therapeutic change. This radically *client*-centred view of the therapeutic process has been adopted and developed by other leading figures in the psychotherapy field, such as Duncan, Miller and Sparks (2004), and *client factors* are now widely accepted as a key element of therapeutic change (see, for instance, Cooper, 2008).

Such a perspective on the therapy process opens up to the person-centred community opportunities to go beyond even Rogers' (1957) original formulation of the necessary and sufficient conditions for therapeutic personality development, and to look at how such factors as client participation, motivation and resources may also be central to facilitating client growth. At the heart of David Cain's (2010) reformulation of the optimal conditions for constructive therapeutic change, for instance, is a client who is 'actively involved and receptive in the therapeutic endeavour, participates cooperatively, and has a positive expectation that therapy will be helpful' (p. 158) (see Chapter 17).

Developing our understanding of, and work with, different client groups

Traditionally – and in contrast to a more medicalized perspective – person-centred therapists have *not* attempted to tailor their theory or practice to particular groups of clients (see Chapter 29), preferring to see the same set of therapeutic conditions as being of generic, universal value (see, for example, Rogers, 1957). As a rejection of a diagnostic, categorizing, de-personalizing worldview, this can be considered to be one of the great strengths of the person-centred approach. Yet there is also evidence that specific groups of clients, such as those from the gay, lesbian and bisexual community, *do* want their therapists to have a specialized understanding of *their* particular issues and context (Burckell & Goldfried, 2006), helping the therapist to understand, accept and engage with their experiences more deeply.

An important future development for the person-centred field, therefore, may be to enhance its understanding of practice with specific groups of clients – particularly when the client comes from a background, or has experiences, that are quite different from the therapist's own (see Chapter 29 on working across difference and diversity). This is explored throughout Part III of this book, which looks at the application of person-centred work to children and young people (Chapter 18), couples and families (Chapter 19), older people (Chapter 20), people experiencing bereavement and grief (Chapter 21), contact-impaired clients (Chapter 22), clients who experience

difficult processes (Chapter 23), traumatized clients (Chapter 24) and clients with addiction problems (Chapter 25). Tolan and Wilkins' (2012) recently published *Client Issues in Counselling and Psychotherapy* also looks at the application of practice to a range of client groups. The issue of tailoring practice to particular client characteristics also raises the question of the role that assessment and formulation might have in person-centred practice, and this is discussed in detail in Chapter 27.

Developing our political acumen

Research may be critical to reversing the eclipse of person-centred therapies by ESTs in some parts of the globe, but developing the political awareness and acumen of the person-centred community may also be an essential step. As Cornforth and Lambers (2010) suggest, person-centred therapists have not been sufficiently visible within political circles; in part, this may relate to the overall philosophy of the person-centred approach, which tends to favour small-scale, local relationships over engagement in the wider public sphere. However, in areas such as Scotland, the person-centred community is now becoming more politically active and savvy. As Cornforth and Lambers (2010, p. 35) write:

> there are signs that there is a growing determination amongst PCE practitioners to find a way of communicating with those who hold political power in Scotland to ensure that the evidence for the effectiveness of the person-centred approach is heard.

Developing international links

One of the strengths of the person-centred world is its degree of international presence (see Chapter 33). This may be an invaluable resource in developing and maintaining the person-centred community at a global level. Here, WAPCEPC can act as a key lynchpin, with its journal *Person-Centered and Experiential Psychotherapies*, as well as other international forums and networks such as PCE Europe or the North-American based Association for the Development of the Person-Centered Approach. Strengthening international links may be particularly important in helping to develop the research evidence, for instance through collaborative international research networks and through learning more from research conducted in other areas. For instance, in Japan, there is considerable expertise in Basic Encounter Groups (Shimizu, 2010).

Making links with other approaches

While the person-centred approach, as discussed above, has a range of very particular contributions to the field, it would be wrong to assume that they are *entirely* unique to us. In taking these contributions forward, therefore, it may be important

to link up with others who are advocating similar perspectives and who may have resources and ideas to develop these foci in original and more compelling ways. For instance, with respect to the development of in-depth relating, colleagues from across a range of fields – including psychodynamic (Stern, 2004), gestalt (Hycner & Jacobs, 1995), existential and feminist (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) – are also exploring the value and function of this mode of relating and its relationship to early developmental processes. Similarly, developments in *client-directed* approaches to therapy closely parallel some key person-centred tenets (Duncan et al., 2004; Hubble, Duncan, & Miller, 1999; Murphy & Duncan, 2010), while some positive psychologists, as Stephen Joseph and colleagues have argued (Joseph & Worsley, 2005), may also be very important allies in the development and dissemination of key person-centred ideas about wellbeing, growth and change.

Interestingly, social theorist William Connolly (2005) suggests that one pathway towards a greater acknowledgement, and appreciation, of diversity outside a field is to acknowledge and appreciate the diversity *within* it. As Sanders discusses in Chapter 4, the person-centred approach is not a single homogenous entity but a broad and heterogeneous ecology of ideas and practices, with a great deal of internal debate and variation. Recognizing, and valuing, this helps us to ensure that we do not create a rigid boundary between 'inside' and 'outside' the field and allows for a smoother and more fluid exchange of ideas and practices.

Allies at higher level of policy-making should also not be ignored. For instance, within the UK, recent years have seen a 'growing trend in health care towards patient empowerment and greater patient choice' (Ford, Schofield, & Hope, 2003, p. 590). Terms such as 'personalization' and 'person-centred care' are now evident throughout government policy documents (Department of Health, 2010), and although these terms may be used in very different ways from those we are familiar with, they highlight the potential for synergies, collaboration and influence at the very highest level of political activity.

From a person-centred perspective, perhaps the most important links to be made are also with service users themselves, either individually or through organizations such as the Mental Health Foundation (UK) and the US government-funded Substance Abuse and Mental Health Services Administration, where the first-hand knowledge of consumers has been an important force in transforming the mental health paradigm from treatment and maintenance models to recovery models. Training materials for the approach Recovery to Practice, for instance, include language that echoes client-centred practice, referring to the fact that it is to be:

> *relationship-based*, emphasizing the healing context in which specific services should be delivered. … *person-centered*, embracing the whole person (not just the illness or pathology) and centered on achieving life goals. And, most of all, they will be *hopeful* and *strengths-based*. (original emphasis)

The Mental Services Act in California, enacted in 2005, also mandates services that are 'client-centered, family focused and community based' (Mental Health Serv-

ices Act, 2005). This state-wide mandate, driven by consumer groups, is in turn driving changes to the training curriculum to adopt an underlying philosophy of care that is strengths-based, recovery-oriented and non-pathologizing.

Consistent with an approach that roots itself in a commitment to clients and their choices and preferences, the person-centred world can do much to learn from and draw on the knowledge of *experts by experience*, helping to orientate the approach more fully around the voices, needs and preferences of those it is intended to help.

Establishing person-centred principles as the basis for integrated practices

Articulating the particular contribution of the person-centred approach to the landscape of integrative practices raises the question of whether or not these contributions could actually serve *as* the basis for an integrative approach. This is the perspective taken by several authors in the person-centred field (Bohart & Tallman, 1999; Cain, 2010; Cooper & McLeod, 2011a, 2011b; see also Chapter 17) and can be seen as another means of meeting – and growing through – the challenge of integrative and eclectic therapies. Integrative person-centred practices are, of course, nothing new (see, for instance, Keys, 2003; Worsley, 2004). Indeed, Cain (2010, p. 62) writes, 'I suspect a substantial portion of person-centered practitioners are, in fact, integrative, as relatively few adhere to a strictly classical, client-centered model'. But what is, perhaps, newer, is the attempt to develop integrative practices *specifically* based on person-centred principles and values, and to establish frameworks whereby these practices can be developed and expanded through research and theory.

The starting point for each of these integrative approaches is that it is the client, as discussed above, that is the principal agent of therapeutic change (see Chapter 6) and that different clients are likely to want – and need – different kinds of input from their therapists (Bohart & Tallman, 1999; Cain, 2010; Cooper & McLeod, 2011a, 2011b; see also Chapter 17). On this basis, it is argued that it is legitimate for person-centred therapists to go beyond purely classical client-centred ways of engaging (such as *empathic unconditional response processes*; see Chapter 11) and draw on a wider repertoire of therapeutic practices, if and where they are skilled in such methods, and if and where clients are keen to engage in these practices. In contrast to the syncretic integrationism discussed above, however, the emphasis here is very much on orientating such practices around clients' individual wants and needs, such that the practice retains a strongly *client*-centred emphasis.

Advocates of a person-centred-based integrationism argue that such an approach provides a means of being person-centred in a person-centred way (Cooper & McLeod, 2011a, p. 221), offering person-centred therapists 'a means of moving away from any fixed concept of self as a "person-centered adherent," to a more fluid and creative actualization of their full potentialities' that is also more responsive to their individual

clients. It is also advocated as a means of establishing links with other members of the therapeutic community – both through the incorporation of practices from different orientations, and through consolidating links with other client-directed approaches (Hubble et al., 1999). Here, the criterion for whether links to other approaches can justifiably be made remains the image of the human being and the ethical stance. Critics, however, may argue that such an integrationist standpoint – by opening practice up to more directive and technique-based methods – is a betrayal of the very principles of person-centred therapy (Rogers, 2010).

Extending person-centred approach concepts and practices into the sociopolitical realm

As will be discussed in more depth in Chapter 32, Rogers was throughout his career as interested in the application of client/person-centred practice in the sociopolitical realm as he was in developing approaches for psychotherapy with individuals. From his first publication on Christian internationalism in 1922, to his last projects on Cold War peace-making with colleagues in the Soviet Union and mutual understanding in racially segregated South Africa, he and his colleagues sought ways to apply person-centred principles to a range of social issues.

A review of person-centred publications in the decades since Rogers' death might lead one to believe that there is little focus on such social issues today. But such a conclusion would miss the phenomenon that Paul Hawken (2007) has called the 'largest movement in history', in which an explosion of initiatives towards social justice, empowerment, peace and sustainability is underway all across the world, most of which embrace foundational ideas that reflect Rogers' discoveries about effective communication and the core conditions for positive change.

Not surprisingly, these initiatives do not necessarily identify themselves as 'person-centred'. In the sociopolitical world, interventions are evaluated and adopted on the basis of their utility, economy and ease of adoption rather than their theoretical lineage. The great diversity of identities, backgrounds, multidisciplinary professional frames of reference, levels of experience and socioeconomic status and political orientation means that questions of orthodoxy are less important than results, and to avoid unnecessary ideological friction, only rarely are change practices identified with any particular named approach. That said, a review of the descriptions of many innovative social programmes suggests that person-centred principles are in operation in a wide range of initiatives around the world in settings as diverse as rural Ghana and industrialized Scotland.

Discussion

As Rogers' (1951, 1959) theory of personality development highlights (see Chapter 8), external challenges can push us all too easily into hunkering down and defending a fixed and resistant sense of identity. So the challenge is to remain *expansive*, to see the

threats as new opportunities for growth, and to learn and respond in flexible and fluid ways – making the best of the circumstances presented to us to actualize the potentiality of the person-centred movement.

In this introductory chapter, we have described some very real challenges – and threats – to the person-centred movement. Yet if we can remain open and responsive to the challenges, we have the potential to evolve and improve, contributing not only to our own betterment but also to the world around us. We have suggested that we may be able to do this in four main ways: developing, and learning from, the evidence base; articulating our strengths and our particular contributions to the wider therapeutic field; developing person-centred values as the basis for integrative practices; and extending person-centred concepts and practices to the wider social field. There are almost certainly many other constructive ways to respond, and we hope that readers, through their own dialogues and through engaging with the chapters in this book, will be able to articulate and communicate their own perspectives.

Points for reflection

- What, in your eyes, are the most important strengths of the person-centred approach in the field of psychotherapy and counselling?
- What do you consider to be the main challenges facing the person-centred approach today?
- How do you think the person-centred community can best respond to the current challenges?
- How would you like to see the person-centred approach grow in the next 10 years? What is your vision of what it might become?
- What resources and possibilities do you have to enhance the future of the person-centred approach?

Key readings

- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

Introduces, and provides evidence for, a view of clients as active agents of change.

- Cooper, M., Watson, J. C., & Hölldampf, D. (Eds.). (2010). *Person-centred and experiential therapies work: A review of the research on counseling, psychotherapy and related practices*. Ross-on-Wye: PCCS Books.

A comprehensive review of the evidence base for the person-centred approach.

■ Duncan, B. L., Miller, S.D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco, CA: Jossey-Bass.

One example of a text from outside the person-centred approach that develops an understanding of the client that is highly consistent with a person-centred one.

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2

The basic conditions of the facilitative therapeutic relationship

CARL R. ROGERS

The point of view that I represent has often been seriously misunderstood and I hope to give you a clear view of what client-centred therapy or the person-centred approach really is. It is an experiential way of being. Let me indicate some of the distinctive features about client-centred therapy which perhaps sets it a little apart from some of the therapies you may be accustomed to. The client-centred point of view is distinctive because it starts from different premises than many other psychotherapies.

In the first place it relies on a constructive actualizing tendency of the human organism as the motivating force for psychotherapy. I don't find evidence of innate destructive tendencies nor a necessity of keeping human nature under control. We found instead that you can tap a positive force within the individual which is constructive and developmental in nature.

A second characteristic is that it definitely rejects the medical model which involves looking for pathology and developing a specific diagnosis, treatment thinking in terms of cure. That model seems to me quite inappropriate for dealing with most psychological problems. We prefer a model based on personal growth and development. In other words trying to release growth and development rather than thinking of it as a pathology to be cured – one of the distinctive features of the client-centred approach. Our theory develops on our experience with the clients, it is not an arbitrary theory which was developed and then we fit the clients to it.

Why am I talking about 'client', not 'patient'? For me that has a real significance. A patient means someone who is sick, who puts himself in the hands of

the doctor, who feels that the doctor is probably the authority who will tell him what to do. A client, on the other hand, is a self-respecting person who comes to someone else for service: I go to a lawyer for help, what I want is expertise. But I am still the one in charge, I am the one to decide whether to take his advice or not, I am the one who is self-responsible. The use of the term client is to stress the fact that we regard the person coming for help as a self-responsible, autonomous individual who is seeking help and we are trying to provide a climate from which he can find that help for himself. The use of the word client means a greater respect for the autonomy of this person.

The basic hypothesis is that if the therapist can provide a facilitative, growth-producing psychological climate the person himself can move toward greater self-understanding, toward more significant choices toward changing behavior or a change in self-concept. All of the outcomes that we think of in regard to psychotherapy will gradually come about if the therapist can provide an affirmative facilitative climate which permits the actualizing tendency to take over and to begin to develop. One of the most important contributions we have made is trying to define what sort of a climate that is which enables the client to search within himself to develop better insight, to develop better understanding, to bring forth a constructive change in his way of coping with life.

There are three conditions which are essential: that the therapist is himself a real person, a congruent person; that the therapist cares for the client, prizes the client; and that the therapist exhibits a real empathy for what is going on in the client.

Empathy is perhaps most easily described and understood. I believe it to be a process rather than a state. The way of being with another person which is termed empathic has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he or she is experiencing. It means temporarily living in his or her life, moving about in it delicately without making judgments, sensing meanings of which he or she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his or her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful. It means frequently checking with him or her as to the accuracy of your sensing and being guided by the responses you receive. You are a confident companion to the person in his or her inner world. By pointing to the possible meanings in the flow of his or her experiencing, you help the person to focus on this useful type of referent, to experience the meanings more fully and to move forward in the experiencing.

To be with another in this way means for the time being you lay aside the views and values you hold for yourself in order to enter another's world without prejudice. In some sense it means that you lay aside your self and this can only be done by a person who is secure enough in himself that he knows he will not get lost in what

may turn out to be the strange or bizarre world of the other, and can comfortably return to his own world when he wishes. This description makes clear that being empathic is a complex, demanding and gentle way of being.

Teaching this kind of therapy is by trying to teach people what it means to be empathic in that sense, to be non-judgmental and yet to very subtly understand all that is available in the consciousness of this other person and perhaps just a little bit below the layer of consciousness. In being empathic, the therapist is not trying to go back into the past, it's not trying to leap ahead into the future, it's trying to catch the meaning that is real to the client at that moment. What the client is talking about might have reference to the past or reference to the future but the meaning he is talking about is an immediate meaning, is that meaning what we would like to be sensitive to, enter into and be a companion to.

The second attitude that is important is an attitude of prizing the client or caring for the client and having an unconditional positive regard for the client. It is not always easy to care for the person who comes to you. The kind of caring I am talking about is at its best when it is a non-possessive, non-judgmental caring. It is perhaps most similar to the feeling that a parent feels toward a child, where a child may misbehave at times, may do things that are wrong in the parent's eyes but overall the parent prizes that child, regards the child as someone of worth, someone to love and care for, regardless of specific behaviors. That type of caring is most effective in therapy. It is something that the therapist cannot order within himself. But the relationship is going to be more profitable if that kind of caring exists. A term I have sometimes used for caring is 'unconditional positive regard'. It is a positive caring which has no conditions attached. If I say, 'Well I like you when you do such and such but not when you do this other thing', that is a conditional kind of caring and we often see parents to do that kind of caring. There is no doubt that has certain values, too. But for the emotional growth, for the development of the individual, the relationship is best in our experience when the care is really unconditional. When it is a caring for the person as the person is at that moment.

The third condition that we discovered to be important is that in our experience the therapeutic relationship is most likely to be effective when the therapist in a relationship is a real person. I mean that in every sense of the word. If I am in a relationship with another individual I would like to know what it is I am experiencing inside in my gut. I would like to be aware of what I am experiencing in relationship with the client; I would like to be able to express that to the client, if it seems appropriate. It means that the client is in relationship not with a person in a white coat, not with a professional, not with a facade but with a real honest-to-God person. That takes away from something that some therapists prize a great deal, namely the professional facade that they put on when they meet someone else. It is more effective when the therapist is himself or herself as he or she is at that moment. For that kind of genuineness we use the term 'congruence' to indicate a matching between what is being experienced inside and what is in awareness in the intellect and what is expressed verbally.

If all those three match in a therapist than I think the client is very fortunate, and constructive personal change is most likely to occur.

In talking about these three conditions sometimes people, in reading about them, have turned them about into shoulds: you *should* be empathic. That is not at all what I am talking about. It is that *if* in a relationship this kind of empathy or of caring exists, *then* the relationship will be constructive, but it is not as though you can tell yourself to be empathic and immediately be there. What I am saying is if these three conditions exist, then change is much more probable. But you cannot order yourself to do that.

You may ask how does change come about in a client in face of these facilitating conditions, how does this produce any effect at all. I would like to give a very simple explanation of it which may help to indicate why these attitudes seem to be effective in therapy. Let us assume for a moment that the client is a woman. If the client finds herself really listened to in this intense sensitive and deep way she begins to listen to herself more: 'What is going on in me?' In other words the empathic attitude on the part of the therapist encourages in the client a more sensitive listening to herself. As the therapist exhibits more of a positive and unconditional caring toward the client, the client begins to feel: 'Possibly I am worthwhile, possibly I can care for myself more, possibly I can regard myself with greater respect.' And there she begins to change the often very negative self attitudes which are so common in clients. So it begins to develop a more positive self-concept in the client. In other words what happens in the client is a real reciprocal of what's occurring in the therapist. As the therapist listens to the client, the client comes more to listen to himself or herself; as the therapist cares with a more unconditional caring for the client, the client's self-worth begins to develop. As the client responds in herself in both those ways then the client is becoming more real, more congruent, more expressing of what is actually going on inside.

From the very first we have been concerned in framing our theory, which in turn is based on our practice, framing it in terms which make it possible to investigate it empirically. Back in 1957 I first began to enunciate some of these conditions of psychotherapy as necessary and sufficient conditions. That article (Rogers, 1957) has probably stimulated more research than anything I've ever written and now there is a quite enormous body of research built on the effectiveness of these conditions on all different kinds of clients – so called neurotic clients who come to a clinic, persons on the back ward of the schizophrenia ward in the State hospital, normal people. These conditions describe some very important elements in therapy which have been confirmed by a great deal of research in many different countries.

Key readings

■ Frenzel, P., Schmid, P. F., & Winkler, M. (Eds.). (1992). *Handbuch der Personzentrierten Psychotherapie.* Cologne: Edition Humanistische Psychotherapie.

■ Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103.

■ Rogers, C. R. (1980). Client-centered psychotherapy. In H. I. Kaplan, A. M. Freedman, & B. J. Sadock (Eds.). *Comprehensive textbook of psychiatry III* (Vol. 2, 3rd ed.) (pp. 2153–68). Baltimore, MD: Williams & Wilkins.

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Note

Condensed version of a talk, based on Rogers (1980), given to psychotherapists at the Medical Faculty of the University of Vienna, Austria, 2nd April 1981. Transcript by Aglaja Przyborski and Peter Frenzel; title and abridgement by Peter F. Schmid. First published in German translation in Frenzel, Schmid and Winkler, 1992.

Part I

Theoretical, historical and philosophical foundations

Edited by Peter Schmid

Unlike many other schools of therapy, the person-centred approach deliberately sprang from an image of the human being. Therefore ethics, anthropology, the philosophy of human relationships and epistemology are not seen as a *meta-psychology* (that is, beyond psychology) but as foundations for understanding the theory and practice of psychotherapy. The approach has reflected its basic beliefs from the very beginning.

As a result, person-centred psychotherapy considers itself much more 'a way of being with' (clients) than a 'method of doing' (something to clients) or a set of techniques to be practised by an expert on successful or happy human living. This does not mean that 'whatever you do' might be fine as long as you have in mind doing something good 'for' the client. On the contrary, doing follows being; in other words, what therapists do in their mutual relationships with clients must be consistent with their idea about the 'functioning' of human beings and the ethics of a person-to-person relationship. Therefore person-centred therapists are continuously being challenged to reflect their practice in the light of the fundamental assumptions on human existence and its consequences.

Therefore the basic beliefs and foundational areas for understanding human living and living together are the subject of the first part of this Handbook. They culminate in a trust in human beings' tendency to constructively actualize their potential to grow and develop if a facilitative relationship is provided. By such personality development, humans increase their ability to tap into their resources in order to help themselves by solving their problems or learning to deal with them. Why person-centred therapists have good reasons to adhere to this trust is covered in Part I, while Part II describes how this trust realizes itself in the therapeutic relationship.

We start with a look into history. In Chapter 3, Godfrey T. Barrett-Lennard, student and long-term companion of Carl Rogers, depicts the way in which Rogers came to his ideas and thus how the person-centred approach came into being. A historical overview of the ground-breaking development of the early years of the approach will help readers to understand how the basics of the approach are rooted in ongoing experience and research.

Chapter 4 jumps to the other end of history: the present, multifaceted appearance of person-centred therapies. Pete Sanders describes the most

prominent members of the 'family' – orientations that are grounded in person-centred experience and thought, or have these as a major source of their self-understanding. (This will be further elaborated on and discussed in Chapter 17, from a more integrative point of view, by David Cain.)

Next we delve into philosophy. The anthropological, relational and ethical foundations of person-centred therapy are discussed in Chapter 5 by Peter F. Schmid. Here he examines the key concepts that underlie the trust in the client's capacity for constructive personality development: the understanding of psychotherapy as a dialogue, the notion of an image of the human being as a person and the understanding of the fostering relationship as encounter. Furthermore, he argues that such an understanding regards person-centred psychotherapy as a Thou–I relationship that proves therapy as a primarily ethical undertaking.

These philosophical positions are explained in the following chapters through fundamental psychological conceptions. Chapter 6 by Arthur C. Bohart delves further into the understanding of the human being as a person by describing the concept of the actualizing person. He explores the actualizing tendency and its connection with the view of an overall formative tendency, the central theory of the self and its actualization, and the hypothetical fully functional person as a blueprint for grasping the direction of the person's development under optimal conditions.

In Chapter 7, Mick Cooper and Arthur Bohart show that the phenomenological stance of this approach, and the experience-oriented understanding of person-centred therapy, require one to deal with the centrality of the experiencing process in the client and in psychotherapy, a viewpoint developed in the approach of Eugene Gendlin.

The developmental aspects of being and becoming a person, together with contemporary critiques and developments of Rogers' classical model of developmental psychology, are the subject of Chapter 8, written by Mick Cooper, which focuses on personality theory.

Martin van Kalmthout is the author of a newly written chapter (Chapter 9) on the spiritual aspects of this image of the human being and its consequences for psychotherapists' self-understanding of and for therapeutic practice.

3
Origins and evolution of the person-centred innovation in Carl Rogers' lifetime

GODFREY T. BARRETT-LENNARD

This chapter discusses:

- Rogers' family background and early travel and academic history, contributing to the forming of his ideas
- The opening phases of his formulated thought and development, leading on to his work at the University of Chicago
- Aspects of the 1930s and Second World War eras that crucially influenced his outlook and rapid advance
- The steps from Rogers' 1951 book to his ground-breaking formulation of the basic conditions for therapeutic change
- The outpouring of research and development that followed Roger's conditions theory and his meta-conception of personal functioning as ranging from stasis to flowing process
- Rogers' later pioneering work in education, intensive small and large groups and peace workshops, continuing to the end of his life

Knowing how a major development began and unfolded creates the possibility of understanding it in depth. The fact that Carl Rogers was an American and that he grew up, lived and worked in particular historical times has great bearing on the nature and impact of his contribution. Already an adolescent when the USA

entered the First World War, Rogers' tertiary education and first professional steps occurred in the 1920s. He then worked full time as a practitioner psychologist through the Great Depression and 1930s, and launched into his academic career and ground-breaking contribution during the Second World War. His innovative trajectory continued to the end of his life in February 1987.

Carl Rogers: personal origins and influences

Rogers was a middle child in a religiously strict, socially conservative and close-knit family. He grew up in Chicago and the country nearby, before and during the First World War. The family atmosphere was judgemental, not directly expressive of feeling yet also strongly valuing of its members. As a child, Carl's rich imaginative life existed side by side with a family emphasis on pursuits of a very practical nature. In school, he was confident of his abilities and excelled in English and science (Rogers, 1967, pp. 346–7).

Looking back, it seems that the stage was set either for Carl to pursue a bounded pathway that continued many of the family norms, or for a difficult, distinct breakout to a different balance of life meaning and purpose. Family-based assumptions about his abilities, and about the importance of integrity, working hard and taking responsibility, no doubt stood him in good stead as he explored and found his way.

As an undergraduate at the University of Wisconsin, his inherited religious interest triggered involvement in a Sunday morning discussion–exploration group, facilitated non-directively by one of his professors. The experience with this group of 'real closeness and intimacy' outside his family was a new and very important developmental influence (Rogers, 1967, p. 349). The next year, participation in a form of religion-based 'Peace Corps' of student volunteers inspired Carl to the career goal of going into Christian work, and he switched his major studies from agricultural science to history.

A further and profoundly influential episode began with his selection as one of 10 students from the USA to take part, in 1922, in a World Student Christian Federation Conference, in Peking (now Beijing). The trip, beginning just after Carl's 20th birthday, was a 6 months' long experience (travelling by sea) with a band of other bright, enquiring participants. By the time Carl got home, it was clear that the written accounts he had mailed ahead, implying a 'radical' change in outlook, were producing a mental and emotional separation from his parents (1967, pp. 350–1). Concurrently, another primary attachment was developing in his life: a closely sharing love relationship. He and his sweetheart Helen married right after Rogers' graduation and headed for New York, to begin the next phase in Carl's educational journey.

Rogers intended to build from his liberal arts studies and religious interest, and devote himself to pastoral ministry. His choice of the Union Theological Seminary, which was notably searching and liberal in its thrust, worked to facilitate discovery of his own path. One high point was a self-organized but approved credit seminar

entirely reflective of the participants' own questions and searching, through which most of them 'thought their way right out of religious work' (Rogers, 1967, p. 354). Carl had already sampled courses in Teachers College, Columbia University, and transferred into doctoral studies there, in clinical and educational psychology.

Training in accord with this new direction included a year-long fellowship in the Institute for Child Guidance in New York, where the ethos of 'eclectic Freudianism' counterbalanced the objective, measurement-oriented emphasis of the Teachers College programme (Rogers, 1967, pp. 356–7). After this eventful scholarship year, and with his dissertation focused on child adjustment and well on the way, Rogers secured (in 1928) his first regular job, as a psychologist. The setting was a monitoring and service agency for children and families established by the Rochester Society for the Prevention of Cruelty to Children. What mattered to Rogers was the opportunity there, realized over the 12 professionally formative years that followed, to do work that interested him with people.

The incubation phase of client-centred therapy

With a wealth of practical experience already under his belt, and a desire to advance and make a difference in his field, Rogers worked on his first book, published in 1939 as *The Clinical Treatment of the Problem Child*. The text reflects a close study of pertinent literature, but its organization and described practice came substantially from the author's own experience working with a young clientele. Parent participation was very uneven but sufficient for a valuable vein of experience that contributed to Carl's later direction in adult psychotherapy. The book charted an almost new field and was a well-regarded and timely resource.

Rogers uses the term 'treatment' frequently and with broad meaning in this work. Aside from therapy, changing a child's environment by placement in a foster home, or by working to modify parents' attitudes or a school's response, or by using carefully chosen group and camp experiences, were alternatives to draw from after diagnostic appraisal. To readers aware of Rogers' later (1951, pp. 219–27) view that external diagnosis in psychotherapy is mostly unhelpful, his early emphasis on its crucial function may come as a surprise. Evidence from tests, interviews, referral reports and other sources were fitted within an original framework of eight 'component factors' that needed to be jointly weighed as a basis for decisions on treatment. One large component was that of family influence, especially the attitudes and response of the child's parents. The author's first discussion of personal psychotherapies (1939, pp. 191–209) falls within his discussion of treatments that have potential to change parent attitudes.

Rogers' account here is that of a searching reporter and synthesizer of core ideas and procedures from two main approaches: 'interpretive therapy' (psychoanalysis) and 'relationship therapy'. Speaking of the second approach (Allen, 1942/1947; Rank, 1936; Taft, 1933), he stressed that 'the relationship between the worker and the parent is the essential feature' (Rogers, 1939, p. 197), especially the aspect of

the worker's non-judgemental acceptance. The primary value of this approach, Rogers suggests, lies 'in the fresh viewpoint of non-interference and reliance upon the individual's own tendency toward growth which it has emphasized' (p. 200).

The professionally very fruitful Rochester years positioned a person of Rogers' talent, interest and drive for another level of contribution. And, by the time his first book was completed, what was to become non-directive client-centred therapy was germinating strongly in the thought and practice of its founder (Kramer, 1995; Rogers & Russell, 2002, pp. 11–12, 111–13; Thorne, 2003). Its fruition came in academic settings.

The new therapy coming to fruition: steps writ large

Rogers' book and already exceptional experience and record of leadership underpinned his appointment, in January 1940, as professor of psychology at Ohio State University. He was quickly in demand for the supervision of thesis studies, and the collection of interview records and other data for research started in short order. He further formulated his ideas on the therapy process in an address at the University of Minnesota in December 1940. Of the response to that episode, he later wrote, 'I began to believe that I might personally, out of my own experience, have some original contribution to make to the field of psychotherapy' (Rogers, 1974, p. 8). He did not look back, the gestation phase was over, and the offspring became non-directive client-centred therapy.

In this 'newer therapy', the therapist–client relationship is seen as the crucial vehicle for change. Main attention is given to presently felt experience rather than analysis of the past. The therapy is seen as an orderly sequence, with the individual's own decision to come for help as its vital launch point. Further described steps culminate in the client's experience of a diminished need for help and a recognition that the therapy relationship must end (Rogers, 1942a, pp. 30–44). There is no doubt now of Rogers' own advocacy of the newer approach. The originality of his founding statement centres on the highly distinctive mode of practice, in which the consistent and versatile application of the therapist's reflection and clarification of feelings and personal meaning was without precedent. The generous illustrations from recorded therapy interviews include the famous verbatim record of an eight-interview therapy case (1942a, pp. 261–437).

The author was already able to draw on the first of the formal therapy research studies stimulated by his work. These included Porter's doctoral dissertation (1941), which systematically compared the interview behaviour of counsellors classified as clearly directive or as non-directive in orientation. A study by Victor Raimy (1943/1948) helped to initiate the development of self-theory as a central axis in Rogers' forming theoretical system. Other studies broke new ground, and fresh papers flowed from Rogers' own pen: on learning from interview sound recordings (1942b), on a study of insight in the counselling process (1944a), and on adjustment difficulties and counselling with returning servicemen (Rogers, 1944b).

Rogers' meteoric advance led next to an offered professorship at the University of Chicago – an irresistible opportunity to establish his own counselling and research centre in a top-flight university. But first he was committed to teach 'simple counselling methods' to the staff of the United Services Organization across the USA, who 'were being besieged by servicemen with personal problems' (Rogers, 1967, p. 363). To this end, a special-purpose book was prepared (Rogers & Wallen, 1946). For the first time, the term 'client-centred' was used side-by-side with 'non-directive'. Counsellor attitudes at the core of a non-directive helping stance included belief in an inherent potential for adjustment and growth, and a commitment to facilitating self-understanding and acceptance. The authors briefly suggest a link with the broader societal context: '*It is perhaps no accident that this emphasis in counselling has reached its fruition in America*' (Rogers & Wallen, 1946, p. 23, emphasis added). In hindsight, this was an understatement. 'America' had come through a convulsive socioeconomic emergency and major war, under a new kind of national leadership, which combined to encourage Rogers' directions and accelerate his career.

Societal emergency, leadership and war: their impact on Rogers' career

The forces at work during the Great Depression of the 1930s and crisis years of the Second World War were transformative. By the time Franklin Roosevelt took office as President, at the depth of the Depression, 15 million Americans had lost their jobs (Leuchtenburg, 1963). The nation itself was under acute stress, and a 'societal crisis therapy' was called for. Roosevelt's unique assets for his job flowed in part from a huge crisis in his own life. He had contracted poliomyelitis some 15 years earlier and was utterly determined in his rehabilitation. Wheelchair-bound, he went on to live with full and extraordinary energy, further sensitized in his human awareness through his health crisis and self-propelled recuperation. He re-entered politics, presiding and learning as New York governor through the darkest period of the Depression.

In 1933–34, as president-elect and then in office, Roosevelt called on an array of key advisors and collaborators, drawn from the academic and professional communities. These included people trained in the field of social work and experienced in innovative programmes for structurally disadvantaged groups, people who shared John Dewey's belief in social intelligence as a foundation in structuring society for human benefit (Leuchtenburg, 1963; Milkis, 2002). In an initial 100-day ferment of presidential initiatives and public response, Congress passed a raft of major laws (Leuchtenburg, 1963), inaugurating a great net of economic and other protection and opportunity. A tidal change in public morale occurred, to which Roosevelt contributed personally through his unique and frequent 'fireside chats' beamed by radio directly to the American people.

Roosevelt's perceptive and highly communicative personal style no doubt contributed to his tremendous rapport with ordinary people (Perkins, 1947). Their confidence in him was further affirmed by his landslide re-election as President, in

late 1936. In the meantime, far-reaching national social security legislation was introduced, in 1935. A component programme, under the heading 'Aid to Dependent Children', was of likely relevance in Rogers' work. He and Roosevelt had in common a stance that was both visionary and highly pragmatic. Perkins (1947, p. 156) notes, for example, that on programme and policy issues, Roosevelt's question always was 'Will it work, will it do some good?' Carl Rogers' self-acknowledged pragmatism – 'Does it work? Is it effective?' (1967, p. 358) – echoes the same attitude.

The direction of Rogers' community-based work in Rochester was in keeping with the government's concern to establish and support programmes on behalf of the more vulnerable and needy groups in society. Citizen participation in decision-making also increased in a great variety of contexts (see, for example, Leuchtenburg, 1963), and Rogers' therapy was becoming uniquely democratic. The president sought to inform, explain and influence (as Rogers came to do in his own talks), with concern for new awareness and change. He listened well and was unusually responsive as well as strongly initiating. Rogers became a responsive initiator par excellence. Both men held an essentially optimistic view of human nature. People in all walks of life and in extraordinary measure felt themselves to be in relationship with Roosevelt. Engaging with Rogers personally, or even through his luminous writing, was a strongly relational experience.

From childhood, Carl Rogers was an avid reader (Rogers, 1967), and literary voices of the 1930s made a powerful contribution to visions of human nature and social need. William Faulkner's human process-focused writing came to full flower and prominence then (Thorp, 1955). John Steinbeck's socially oriented novels, which soared into prominence during the 1930s, evoked images of suffering and strength in ordinary people in ways that were reminiscent of Rogers' egalitarian humanistic emphasis. So too in the cases of Ernest Hemingway and others, including Archibald MacLeish. Rogers later quoted MacLeish in expressing a viewpoint close to his own heart: 'We do not feel our knowledge. Nothing could better illustrate the flaw at the heart of our civilization. … Knowledge without feeling is not knowledge and can lead only to public irresponsibility and indifference, and conceivably to ruin' (Rogers, 1974, p. 105).

Near the start of his 1942 book, Rogers had related his counselling approach to wartime needs, and to the democratic vision and its preservation. He spoke also of the relevance of counselling in maintaining military morale and keeping men fit for their military roles (Rogers, 1942a, pp. 9–10). For returning veterans, there were difficulties of re-entry to a non-service world of much less regulation and unity of purpose, and of a return to relationships distanced by reshaping war experiences (Rogers, 1944b). Much later, when asked about the response to his 1942 book, Rogers spoke of 'the floods of veterans coming back with problems people hadn't anticipated', and the perception that he 'seemed to have something to say to people who were trying to help returning veterans adjust; so that meant the book skyrocketed and began to have enormous impact. If it had not been for the War I don't know' (Rogers & Russell, 2002, p. 136).

The president's often-expressed concerns reached beyond the war to the quality of the peace that would follow. Words in his last prepared speech, which he did not live to deliver, might have come from within the helping field: 'Today we are faced with the pre-eminent fact that if civilization is to survive, we must cultivate the science of human relationships' (Zevin, 1946, p. 455). The leadership qualities of statesman and psychologist had much in common. Perkins (1947, p. 308) describes Roosevelt's qualitative influence in terms that are strikingly in keeping with Rogers' then-evolving views and style of leadership (Gordon, 1955):

> To sum up Roosevelt's role in the War, I would say that he was the catalytic agent through whose efforts chaotic forces were brought to a point where they could be harnessed creatively. He was a creative and energizing agent rather than a careful, direct-line administrator.

The interested reader will find a much fuller picture in a recent journal article and in my earlier book of the whole terrain of development, connection and confluence outlined here (Barrett-Lennard, 1998, 2012). That features of the times and context particularly encouraged, influenced and supported Rogers in his direction is, in my view, beyond reasonable doubt. Social philosopher and educator John Dewey, a towering figure at the time, helped to mediate this influence by the impact of his work jointly on the New Deal and on Rogers (Barrett-Lennard, 2012; Milkis, 2002; Rogers, 1970, p. 159).

By the late 1940s, Rogers was preparing another major book that brought group work and education as well as adult and child psychotherapy into sustained focus. It was a work (Rogers, 1951) through which client-centred therapy came of age as a well-tried, multisided field of practice and thought. The main author and founder of this widely influential school had not yet turned 50, and already was reaching for a further level of understanding therapy and helping processes.

Honing in on a theory of the (causal) conditions for therapeutic change

Unlike any other school of psychotherapy, client-centred counselling was continually under the microscope of research. A variety of studies, from the early to late 1940s, provided evidence that the therapy discourse was a consistent, ordered phenomenon (see Barrett-Lennard, 1998). This opened the way to a fresh focus on the effects of this known phenomenon. A sample of 29 clients (with 12 different therapists) provided the data for by far the most ambitious study of therapy outcome undertaken to that time, and a dozen interlocking studies were reported together in book form (Rogers & Dymond, 1954; see also Barrett-Lennard, 1998). The logical further question, already in Rogers' mind, was 'what exactly, in the therapy experience and process, promotes these distinct change effects?

Already, in 1946, Rogers was on the track of a systematic formulation of the conditions for therapeutic change. At that time, he distinguished six needed features of therapist attitude and behaviour (Rogers, 1946, p. 416):

- that therapists regard their clients, first, as self-responsible and, second, as inherently motivated toward development and health;
- that they create a warm, permissive, accepting atmosphere;
- that any limits set on behaviour do *not* apply to attitudes and feelings;
- that therapists respond with a 'deep understanding of the emotionalized attitudes expressed', especially through a 'sensitive reflection and clarification of the client's attitudes';
- that they abstain from probing, blaming, interpreting, reassuring or persuading.

'If these conditions are met', he proposed *in 1946*, healing and growthful process will be reflected within therapy and in awareness and behaviour beyond therapy.

In a subsequent paper, Raskin argued that a genuinely non-directive *attitude,* centred on the client's feelings and frame of reference, was the central therapist quality that underpinned true acceptance and created the potential for understanding in depth (Raskin, 1948). In close sequence, Rogers focused on the central importance of coming very close to the client's experience, even seeing and feeling this experience almost as the client was. However, he distinguished empathic from emotional identification, and pointed out that empathic recognition and response does not involve self-entanglement in the other's feelings (Rogers, 1949, p. 86). Soon the term 'empathic understanding' is mentioned, although not yet defined (1951, p. 29). So too with the idea of genuineness of response.

Rogers spoke (1953) of the positive feelings that can naturally arise towards a client sharing his or her innermost consciousness in a sensitive difficult search for deeper connection and wholeness. Respect that ignites into spontaneous warmth, even affection, can be part of the human reality of a deepening helping relationship. Standal, working with Rogers, would have begun his thesis exploration (1954) of positive regard, viewed as a basic human need and ingredient of therapy. Standal's study also brought into view the idea of 'conditions of worth', referring to entrenched beliefs about acceptable and unacceptable personal qualities, beliefs acquired in relations with significant others – hence also the concept that the therapist's positive regard needs to be unconditional to help undo the client's self-devaluing or censoring conditions of worth (see Chapter 12 for a study of thought and illustration focused on this feature).

In his mid-1950s 'current view' of client-centred therapy (published in 1956, pp. 199–200), Rogers gives primary importance to the therapist being 'genuine, whole, or congruent in the relationship'. If the client is to venture into the reality of self, the therapist needs to be open and transparent in this relation (see Chapter 13). Therapist (genuine) acceptance or unconditional positive regard (both terms are used) is a second vital factor, and the therapist's desire and ability to understand with sensitive empathy is the third ingredient of the relationship (see also Chapter 11). By 1956,

Rogers' sustained pondering and refinement of ideas had moved him, via the steps mentioned, to a rearranged sharper articulation (privately circulated in his counselling centre) of the conditions for therapeutic change. This bold formulation, published the next year (1957), gave a new level of clarity and force to the cause-and-effect equation of therapy that had been trialled a full decade earlier.

Why did the new formulation have so much impact, even for Rogers' students (of whom I was one) and for others in his field? The clear logical form of his direct unqualified portrayal of the six crucial change-producing conditions made it arresting. The economy of the theory and the idea of sufficiency – that the equation was complete – added force for many readers. The boldness of Rogers' claim that these were the fundamental underlying conditions for healing and growthful change in any psychotherapy woke people up. By now, the author was a leading – even famous – figure in his field; his asserted 'general theory' could not simply be ignored: and blood pressures rose in some quarters. Just one basic client quality was singled out as necessary, that of incongruence – implying inner division and conflict. For the other conditions to be realized, it was necessary that client and therapist be in 'psychological contact' (see Chapter 10), especially that the therapist be distinctly present to the client (see Shari Geller's valuable discussion in Chapter 14). Finally, the crucial features of the therapist's congruent, unconditionally regardful and empathic response needed to be registered and have reality for the client. Under these conditions, constructive personal change would occur.

That was the whole theory, in a nutshell, and it immediately triggered groundbreaking fresh research, supported further authenticity in the therapy relationship and led to an extension of Rogers' principles in a wide range of helping relationships.

The conditions and process of therapy: investigation and development

Therapy practice has tended to move ahead of theory and research. By the *beginning* of the eventful decade of the 1950s, a prescient therapy client had written that her counsellor (almost certainly Rogers) 'would say to me things which I had stated but he would clear them for me, bring me back to earth, help me to see what I had said and what it meant to me', and he 'was almost part of me working on my problem as I wanted to work on it' (Rogers, 1951, pp. 36–7). Clearly, the client saw the therapist as with her in a potently clarifying way, a way that implied a depth of *empathic understanding of her experience and search for meaning.* By 1956–57, this core aspect and the associated therapy conditions had come into distinct, compelling, but not exact focus. I say 'not exact' because it was possible for two significantly different operational definitions to be embodied in the first measurements of the conditions in therapy.

Halkides devised scales for *observer rating* of therapist congruence, unconditional positive regard and empathic understanding, using brief interview excerpts taken from 20 therapy cases. Each of these scales, as rated by judges, was significantly asso-

ciated with a separate criterion appraisal of therapy outcome (Rogers, 1965). The different other study was conducted by this author (Barrett-Lennard, 1962; Rogers, 1965). This work tapped directly into the relationship experience of the therapy partners using a new instrument known as the Relationship Inventory. More systematic definitions of the therapist variables to be measured (empathic understanding, congruence, level of regard and unconditionality) were formulated, and a range of items relevant to each variable was generated. Each item was rated on a scale from a strong yes (it is true) to a strong no (not true). Item 17, for example was 'He/she nearly always knows exactly what I mean' (positive empathy), and Item 53 originally read 'S/he is playing a role with me' (negative congruence). In a parallel form for therapists, the same items were worded in the first person. Results supported the theory, particularly using client relationship data. Importantly, experienced therapists provided a more positive relationship than novice therapists did with their equivalent group of clients, *and* the clients with the experienced therapists changed more (Barrett-Lennard, 1962, 1998; Rogers, 1967). From the beginning, the Relationship Inventory was seen as applicable to the study of almost any category of interpersonal relationship. Its extensive use in Rogers' lifetime (and since) involved a wide range of contexts (Barrett-Lennard, 1986, and later reports).

Rogers relocated in 1957 from Chicago to the University of Wisconsin, drawn there by the opportunity to be involved in the training of psychiatrists and to spearhead a major study of psychotherapy with hospitalized clients with schizophrenia (Rogers, Gendlin, Kiesler, & Truax, 1967). Obtaining the relationship data was challenging (both above-mentioned methodologies were used) *and movement in client functioning within therapy* also was investigated. Client in-therapy process level (see Rogers, 1961, pp. 125–59) was tracked using several measures stemming from the new process–stasis conception, yielding a complex pattern of meaningful findings (see the reports and scales in Rogers et al., 1967).

In all, however, Rogers' Wisconsin experience was professionally disappointing, even painfully frustrating to him, both academically and around the management of this research – notwithstanding important new learnings and unfolding interests (Rogers, 1967). Not one to stand still, he accepted an enticing offer in California and in 1964 embarked on a freeing new phase of his career. His pioneering now centred on education and personal development through experiential groups.

Pioneering intensive work with small and large groups

Rogers had long engaged in a facilitating role in groups, especially in the manner of his teaching and leadership. Shortly before leaving Wisconsin, he initiated intensive residential group workshops (Rogers & Russell, 2002, pp. 192–3), which helped to launch him on this path of interest (Rogers, 1970). He discontinued dyadic interview therapy, except for demonstrations. Soon he was also resourcefully carrying his new interests abroad in person, in Europe, Japan, Australia, South America and later in South Africa and the Soviet Union. His enthusiastic adoption of small groups

spread to the sphere of education and school systems, though with mixed results as existing controls and boundaries fell away (Barrett-Lennard, 1998, pp. 190–2). Rogers' passionate stance on education was reflected in new books and other writing (for example, in *Freedom to Learn*, 1969, and its later revision).

The focus on small groups as a potent medium for self- and interpersonal learning unfolded into a consuming interest in process-oriented 'community' workshop groups of 100 or more people (Rogers, 1977, pp. 143–85). Rogers' wide-ranging personal involvement in large and small intensive groups and his flow of eloquent reports (see, for example, Chapters 9 and 14 in Rogers, 1980) led to an involvement in peace workshops, especially towards the end of his life. These took place in South Africa (still under apartheid), the Soviet Union and Austria (but with Central American membership and focus) (Rogers & Sanford, 1987). He remained active, with forward planning, and was a nominee for the Nobel Peace Prize when a hip fracture and heart attack after surgery killed him early in 1987. By that time, many other exponents in diverse locations had been conducting intensive groups and/or advancing theory and research on the group process and its effects (Barrett-Lennard, 1975/1976, 1998; see also Chapter 15).

A word on later development

By the time Rogers' life ended, the main push and focus of activity and development in the person-centred sphere was passing from the USA to the UK, Europe and other parts of the world – as further testified by the cast of authors and spread of innovative developments in this Handbook and earlier collections. Only a handful (perhaps a dozen) of closely related volumes in English by other authors came out in Rogers' lifetime. However, building up from the late 1980s, there has been a river of books and journal reports from person-centred authors in the UK, Europe and elsewhere. Substantial volumes flowed from the Person-Centred and Experiential Psychotherapy international conferences beginning in 1988. Major publishers such as Sage developed a focus on person-centred work, including large-circulation texts (see, for example, Mearns & Thorne, 1988, and later editions). A new publishing house, PCCS Books, has since 1993 provided great opportunity and impetus for person-centred authors with a catalogue now numbering over 60 volumes, and the journal *Person-Centered and Experiential Psychotherapies* is now at its 11th annual volume.

Conclusion

Rogers' lifetime was a remarkable journey. He was both a man of his time and setting and a true pioneer in psychology, psychotherapy and other helping relationships, in education, and in work with small and large groups designed to sensitize, empower, dissolve barriers and promote peace. A person of enormous energy and devotion to making a difference, his mission was a liberating one and he opposed orthodoxy – although his fear of the latter in our own field diminished, as seen in his support of

a new person-centred journal (prior to *Person-Centred and Experiential Psychotherapies*) and the beginning of focused training centres in Europe. I can imagine his bemused wonderment were he to be fast-forwarded into the present world of thought and development represented in this Handbook and in the multiplicity and variability of training centres internationally (see, for example, Thorne & Lambers, 1998).

Points for reflection

- What were Rogers' most valuable contributions to theory and ideas? Did he at some stage stop developing fresh theory? Was his later career occupied with new and wider applications of the same essential principles he had much earlier advanced?
- Did history and circumstance make the man in Rogers' case, or was he a pioneer of ideas without precedent that then helped to shape subsequent history in and beyond his field of interest?
- It is now a quarter of a century since Rogers' life ended. Is the person-centred approach still 'Rogerian', or are some later innovations closely rooted in his work while other developments employ certain features imported into contrasting contexts of thought and practice?

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4

The 'family' of person-centred and experiential therapies

PETE SANDERS

This chapter discusses:

- The development of different strands of theory and practice in client-/person-centred therapy
- The core values of the person-centred approach as seen by Germain Lietaer (first- and second-order factors), Pete Sanders (based on the therapeutic conditions and non-directiveness), Peter F. Schmid (criteria for identity and coherence) and Margaret Warner (levels of therapist interventiveness)
- Person-centred/client-centred therapy in its pure classical non-directive client-centred form, encounter-oriented (dialogical) approaches and the meta-perspective of integration
- Experiential therapies such as focusing-oriented psychotherapy, process-experiential psychotherapy, emotion-focused therapy, and Pre-Therapy

Carl Rogers' presentation at the University of Minnesota on 11th December 1940 is widely acknowledged as the birth of client-centred therapy (Kirschenbaum, 1979), and he made his most complete theoretical statement in 1959 (Rogers, 1959). However, theories, like genies, have a tendency to change shape as soon as they are released, and Rogers was at the epicentre of change in client-centred theory during his lifetime. Rogers disliked dogma and rigidity, describing many of his most durable writings as 'tentative'. Indeed, he explained 'the value of

presenting something before you are entirely sure of it' (Rogers & Hart, 1970, p. 520) as he reflected on nothing less important than his 'Necessary and sufficient conditions' (Rogers, 1957) and 'Process conception of psychotherapy' (Rogers, 1958).

Rogers enjoyed developing his own thinking and positively encouraged this in his students and associates. The early years of client-centred therapy at the University of Chicago saw only a brief period as a 'unified school' (Barrett-Lennard, 1998, p. 58), and new developments in theory, research and practice were soon in full flow at an astonishing pace. It is not surprising, then, that it very quickly became difficult to tell where 'client-centred therapy' ended and something qualitatively different began.

Two ways of thinking emerged to cope with this. One held true to the fundamental principles outlined by Rogers in 1959; another favoured developing newer ideas at varying tangents to, yet wholly informed by, Rogers' original work. Hutterer identified these as two poles of a crisis of identity for the approach: one pole the commitment to a set of core person-centred values, the other 'the attempt to free theoretical thinking of rigid concepts' (Hutterer, 1993, p. 275), representing the tension between the pure form and new ideas. This tension defines developments in the theory and practice of client-centred/person-centred therapies since 1959.

In order to fully apprehend the details of the positions and arguments summarized in this chapter, and to accurately position themselves in the 'family' of person-centred therapies, serious students of contemporary person-centred therapies must reconcile themselves to extensive reading.

Readers are first directed to a stream of papers and chapters attempting to resolve a perceived threat of imminent fragmentation of the approach, starting with the prescient 'Roundtable discussion' in the August edition of *Person-Centred Review* (1986), 'In your opinion what is most essential to the continued development of the theory and application of the person-centred approach'. Other notable contributions include those of Hutterer (1993), Lietaer (2002), Sanders (2000/2004, 2004), Schmid (2002b, 2003) and Warner (2000). All are caught on the horns of the dilemma: freedom from rigid theory versus definition of core values. However, there *has* been movement in the 20 years since the inconclusive round-table discussion. The later contributions all attempt to present ways of defining core values that place a premium on *inclusivity* and the *embracing* of difference rather than excluding deviation from the pure form.

Core values as seen by different authors

Germain Lietaer: first- and second-order factors

Lietaer in 2002, building on his 2000 paper, described first- and second-order factors of theory and practice in the client-centred/experiential paradigm. His first-order factors (central to the person-centred 'family') are:

- a focus on the experiencing self;
- moment-by-moment empathy;

- a high level of personal presence;
- an egalitarian, dialogical stance;
- a belief that the Rogerian therapist conditions are *crucial*.

His second-order factors (peripheral to, but particularly characteristic of, the person-centred 'family') are:

- holistic person-centredness;
- an emphasis on self-agency and the actualizing process;
- self-determination and free choice as human possibilities;
- the prosocial nature of the human being;
- autonomy and solidarity as existential tasks.

Lietaer's formulation is clearly influenced by his leanings towards experiential psychotherapy. The terms 'experiencing self' and 'moment-by-moment empathy' are redolent of the experiential thread. Furthermore, he uses the vocabulary of experiential therapy as his benchmarks, which could be seen to imply that a nascent unified paradigm is defined by emerging experiential concepts rather than established client-centred ones.

Pete Sanders: principles based on the therapeutic conditions and non-directiveness

Sanders (2000/2004) introduced the idea of primary and secondary principles based on Rogers' therapeutic conditions and non-directivity. His primary principles (*essential* for inclusion in the person-centred 'family') are:

- the primacy of the actualizing tendency;
- assertion of the necessity and centrality of Rogers' (1959) therapeutic conditions;
- the primacy of the non-directive attitude, at least at the level of the content of the therapeutic encounter but not necessarily at the level of process.

His secondary principles (optional, but particularly characteristic of the person-centred 'family') are:

- autonomy and the client's right to self-determination;
- equality or the non-expertness of the therapist;
- the primacy of the non-directive attitude and intention in its absolute, pure and *principled* (Grant, 1990/2002) form;
- the sufficiency of Rogers' (1959) therapeutic conditions;
- holism: encountering the client as an organized whole entity.

To be included in the person-centred 'family' on Sanders' terms means accepting the necessity (but not the sufficiency) of Rogers' therapeutic conditions and delineating the difference between directing the content of the therapy and directing the

process of the therapy. For Sanders, espousal of the sufficiency of Rogers' conditions and non-directivity in both content and process of therapy would define the practice of the classical client-centred therapist.

Peter F. Schmid: criteria for identity and coherence

Schmid (2003) took a comprehensive look at the characteristics that bring together the 'family' of person-centred therapies and the criteria by which contenders can be evaluated. There is insufficient space to adequately précis all the aspects of his careful analysis here, but for the purposes of comparison, Schmid characterizes person-centred therapies as:

- founded upon an image of the person as inseparably individual and relational;
- relationship-oriented (as opposed to goal-oriented);
- dialogical (see below);
- putting the client first: not meaning simply that the client is at the centre of the relationship but that the client is the expert, emphasizing the phenomenological nature of the approach;
- consisting in the presence of the therapist as non-directive, immediate, open and embodying Rogers' therapeutic conditions.

Schmid is concerned that the public face of person-centred therapy is clearly stated, identifiable and congruent through its practice, theory and principles to its philosophy. This is no small task, but his endeavour, along with that of the others here, is concerned with developing negotiated boundaries between person-centred therapy and other approaches, and with cohesion within those boundaries.

Margaret Warner: levels of therapist interventiveness

Warner (2000) differentiated approaches on the basis of five levels of therapist 'interventiveness', while taking Rogers' therapeutic conditions as the baseline, the minimum qualification for inclusion in the person-centred 'family'. Interventiveness is clearly derived from non-directivity and is defined as the 'degree to which the therapist brings in material from outside the client's frame of reference and the degree to which this is done from a stance of authority or expertise' (Warner, 2000, p. 31).

- *Level 1:* The therapist brings nothing from outside the client's frame of reference.
- *Level 2:* The therapist uses personal experiences and theories in order better to understand (but not influence) the client's experience.
- *Level 3:* The therapist brings material into the relationship in ways that foster the client's choice over whether and how to use such material.
- *Level 4:* The therapist brings material into the relationship from their own frame of reference from a position of authority or expertise.

- *Level 5:* The therapist brings material from outside the client's frame of reference so that the client is unaware of the intervention, its nature or the therapist's purpose in making the intervention.

Warner asserts that client-directed therapies would be found at levels 1–3, while therapies using interpretations, suggestions and techniques would be found at levels 4 and 5. She also suggests that the attitudes implicit in levels 1–3 would be more indicative of therapists who understood the actualizing tendency to be central to the change process. In short, she concludes that although some person-centred therapists might make a few interventions at level 4, her scale places person-centred therapies at levels 1–3.

Classical non-directive client-centred therapy: the pure form

The appellation 'classic' or 'classical' related to client-centred therapy is a somewhat recent development, possibly used first by Lietaer (1990, p. 11) in the form 'classic Rogerians'. As new approaches and integrative variants sprang from the work of Rogers, those theorists and practitioners whose practice was defined by Rogers' early work in Chicago struggled to identify themselves as different from what had become a general mêlée of generic person-centred therapists. Some preferred to identify themselves as 'non-directive' and others as 'client-centred' therapists (to set their work apart from what they saw as the more inclusive term 'person-centred therapists'). Although far from universally accepted, classical client-centred therapy is becoming more frequently used as a descriptor of Rogers' founding formulations (see, for example, Rogers, 1959), with a distinct emphasis on non-directive intent. The practitioners most associated with this original form are Barbara Brodley (Moon, Witty, Grant, & Rice, 2011), Jerold Bozarth (1998) and Tony Merry (2002). Merry gives a comprehensive account of the theory of motivation (actualization), personality (19 propositions; Rogers, 1951) and therapy (Rogers, 1959), with a summary form being published 2 years later (Merry, 2004).

The salient distinguishing features of the classical form are understanding and accepting:

- the actualizing tendency as the unitary motivation for human beings;
- the need for positive regard and ensuing conditions of worth as the fundamental origin of psychopathology;
- the necessity and sufficiency of Rogers' therapeutic conditions for personality change (driven and directed by the actualizing tendency);
- the inviolable sovereignty of the client and the client-centred location of the therapeutic process, represented by principled non-directivity.

Although referred to as classical, original and pure, it cannot be said that this founding formulation does not itself continue to develop. Many practitioners have

elaborated, extended and added to Rogers' original concepts and practice without violating the principles outlined above. An incomplete list of developments includes:

- Barbara Brodley's refining and elevation of the concept of empathy, development of the central role of the 'empathic following response' and origination of 'empathy-only' practice (Brodley, 1996, 2001; Moon et al., 2011);
- Dave Mearns' exposition of working with different configurations of the self (Mearns & Thorne, 2000);
- Dave Mearns' (Mearns, 1996; Mearns & Cooper, 2005) development of the thesis of working at relational depth – a concept having resonance with Rogers' notion of 'presence' (Rogers, 1986) and Thorne's writing on 'tenderness' (Thorne, 1991);
- Barry Grant's elaboration of principled and instrumental non-directivity (Grant, 1990/2002);
- Jerold Bozarth's identification of unconditional positive regard as the 'curative factor' (Bozarth, 1998, p. 83) in personality change;
- most recently, Barry Grant's exploration of the legitimate targets of empathy in classic client-centred therapy, namely *only that which is communicated by the client*, rather than the client's experience. Grant's position is best described in his own phrase that being empathic is 'taking only what is given' (Grant, 2010, p. 225).

Most of these developments are well represented in the literature, and I have chosen two to highlight, for different reasons. The first is Mearns' and Cooper's development of the contentious and popular concept of relational depth (see also Chapter 5). They define it as:

> A state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level. (Mearns & Cooper, 2005, p. xii)

This concept is contentious because some classical therapists are unable to divine quite what it adds to the prospectus of person-centred theory and practice, and other critics believe that it adds too much. Indeed, Mearns also wrote:

> I have always insisted that the concept of 'Relational Depth' adds nothing new to Rogers' theory. It is the same as Rogers' description of the power of the therapeutic relationship. Later, Rogers, for the sake of the science of his time, had to break up his concept of the therapeutic relationship into the core conditions, but we all recognize that their power is in the gestalt created by their combination in high degree. That is what relational depth is. (Mearns, personal communication, 2011)

Research in relational depth is established and growing. For example, Wiggins (2009) is developing a measure – the Relational Depth Inventory – and the concept appears to be validated in the experiences of clients (Knox & Cooper, 2010).

The second development is the elaboration of empathy proposed by Grant (2010). Grant and others position person-centred therapy as an ethical endeavour

and propose therapy as an 'ethics-only' enterprise, beyond theory (Grant, 2004). Related to this is his most recent proposition that the proper target of empathy is located in the client's communications. This resumes, in my reading, Shlien's (1970) attack on interpretation and the unconscious. Grant asserts that therapeutic empathy does not attempt to go below the surface or reflect elements of the client's experience that have not been intentionally communicated. Any such intuitive interventions or invitations to go further or deeper are disrespectful of the client and act against the client's self-autonomy.

These two developments help us to mark the extent of the differences within the family of person-centred theories. In my view, the strength of the family will be judged by its capacity to be inclusive and celebrate such diversity, and not exclude the perceived transgressors of disputed boundaries.

The meta-perspective of integration

In Chapter 17, David Cain takes a more in-depth look at integration. Here, I consider the location of integration in the family of person-centred therapies. Norcross and Goldfried (2005) group methods of integration in psychotherapy into four types: common factors, technical eclecticism, theoretical integration and assimilative integration.

It is important immediately to distinguish between technical eclecticism and other types of integration. Technical eclecticism denotes assembling a collection of techniques according to the requirements of the situation as seen by the therapist or protocol of a model. Although models have been developed, for example Arnold Lazarus's multimodal therapy, none is specifically person-centred in origin, and in practice many practitioners of technical eclecticism apply techniques on an ad hoc basis mimicking the medical approach to treating somatic disease by affecting a 'diagnosis and application of appropriate treatment' method. The many issues raised by this type of ad hoc approach include the fact that there is no scientific basis for such 'diagnoses' (they are therapist 'hunches') – and hence there is scant evidence for the appropriateness of the 'treatments' that might be applied (Sanders, 2005) – and that there is also a lack of a clear conceptual framework describing how techniques drawn from divergent theories might fit together.

Rather than react to the client in an entirely ad hoc way, the integrative *models* referred to by Norcross and Goldfried attempt to develop an effective prospectus for treatment by one or more of the following methods:

- identifying and bringing together common theoretical components;
- identifying and bringing together common techniques and method;
- the development of a meta-theory (possibly derived from the first two points above, or from extending an existing theory).

This gives rise to too many definitions of integrative therapy to mention here, and the idea behind most integrative *models* is still predicated on the notion of 'pure

forms', so it is better to speak in terms of an integrative *approach* to therapy rather than integrative models. And finally, all of this reproduces the tensions in the 'family' of person-centred therapies already described – between the 'pure form' and the 'new developments'.

Within the person-centred field (see also Chapter 17), two integrative approaches of interest to person-centred practitioners use the person-centred therapeutic conditions as instruments (Grant, 1990/2002) to further other therapeutic process. These are the common factors approach and the work of Cooper and McLeod (2011).

The common factors approach (see, for example, Miller, Duncan, & Hubble, 2005), suggests that the factors common to most psychotherapies are the ones that make psychotherapy effective, including:

- things that happen outside therapy (extratherapeutic factors);
- the therapeutic relationship;
- the placebo effect, hope and/or expectancy.

An integrative model is then forged by understanding the type, or school, of therapy practised – with its various attitudes, and interventions – as a way of enhancing the other factors, rather than as contributing an essential, unique ingredient. The therapeutic approach is simply a conduit for delivery of the common factors. In this way, the elements of many approaches that enhance the strength of the relationship, hope, a positive expectation of change, etc., can be brought together with the client's own model of change. This last point is important since one common factors approach also incorporates the idea that the most important common factors are those contributed by the client – the client's own 'self-righting' ability. This version of common factors integrative therapy is supported by the work of Art Bohart, who, with Karen Tallman, highlighted the client's role in the process of change (Bohart & Tallman, 1999; see also Chapter 6).

There are some similarities between Cooper and McLeod's (2011) pluralistic counselling and psychotherapy and Worsley's (2004; see below) integrative approach, although the former appears to be a more instrumental progression of:

- establishing a therapeutic relationship based on Rogers' six conditions;
- putting the client's goals at the centre of the therapeutic activity;
- framing the therapeutic project in terms of tasks to be achieved by the client.

This is clearly an integrative approach that will be judged by person-centred practitioners on the centrality and ubiquity of the six conditions.

Richard Worsley (2004) describes an approach to integration that resonates more clearly with person-centred theory and practice – an approach to integrating material into person-centred practice while testing the process against person-centred core theory and exploring the consequences. Worsley advocates continuous reflexive practice that is informed and directed by the central philosophical tenets of collaborative practice, putting the client at the centre of the

activity, respect for the sovereignty of the person, attention to the moment-by-moment experiencing of client (and therapist), and the necessity of the authentic open presence of the therapist. He summarizes this approach thus, 'What is to be integrated is life's experience as a whole!', and continues 'If the practitioner of the classical, client-centred model protests that they also do this, then I am delighted' (Worsley, 2004, p. 128). I wonder if this approach to therapy is what Rogers had in mind when he explained that he did not want anyone to mimic him but to find their own way.

Developments from the 'pure form'

Focusing-oriented psychotherapy

Eugene Gendlin, a student and later a colleague of Rogers, was the first to develop theory and practice springing from, yet at a tangent to, Rogers' work (Hendricks, 2001; Purton, 2004a, 2004b; see also Chapter 17). Gendlin clearly began developing his ideas regarding experiencing in the late 1950s and early 1960s. Gendlin and Rogers (1967, pp. 13–14) explained that 'The basic theory of experiencing as defined by Gendlin (1962) is central to the whole conception' of the framing of the research project at Mendota State Hospital (Rogers, Gendlin, Kiesler, & Truax, 1967) into the effects of psychotherapy with people diagnosed with schizophrenia The work with the clients and the results of the study, together with earlier work by Kirtner and Cartwright (1958), all pointed to the importance of the nature of the client's experiencing as a crucial factor in the outcome of therapy. Although Rogers acknowledged the importance of this, he moved from Wisconsin to California in the early 1960s and to all intents and purposes withdrew from the development of one-to-one therapy theory.

Gendlin, on the other hand, continued to pursue the finding that the client's level of experiencing was important if not essential to the process of change. Those not engaged with their experiencing (a low experiencing level) were less likely to change than those who could apprehend their moment-by-moment experiencing (a high experiencing level). Gendlin turned his attention to developing methods to help clients attend to their experiencing process, literally to pay more attention to their moment-by-moment experience. This is the essence of focusing-oriented psychotherapy (Gendlin, 1996); for more on this, see Chapter 17.

Focusing-oriented psychotherapy sets out first to help clients engage better with their experiencing. The therapist helps the client become aware of any blocks to the flow of their experiencing, which particularly involves the therapist *being* with the client in a way that does not hinder the natural process of healing. This way of being present corresponds with Rogers' therapeutic conditions. It also involves looking at the possibility that the client may be suffering from any number of well-known (to focusing-oriented therapists) difficulties in accessing their experiencing, and inviting the client to work in particular ways to dissolve them.

How does focusing-oriented psychotherapy fit into the person-centred 'family'?

Purton (2004a, 2004b) asserts that focusing-oriented therapy takes Rogers' therapeutic conditions as its starting point for a practice that does not block the client's access to their experiencing, and he asserts that it is essentially non-directive. (Readers must remember that the focusing six-step procedure is *not* a method for therapists.) Differences arise between the pure form and focusing-oriented therapy in both personality theory and the theory of therapy or change.

It is clear, however, that there *are* potential differences in practice between classical client-centred therapy and focusing-oriented therapy. Individual classical client-centred therapy practitioners are obliged to be principled in their non-directivity (Grant, 1990/2002), or work at Warner's levels 1 and 2 of interventiveness, since, as I note elsewhere (Sanders, 2005), classical client-centred therapy is the only approach that enshrines clients' right to access healing without sacrificing their personal power. On the other hand, individual focusing-oriented therapy practitioners *may* operate at levels 4 and 5 if this will facilitate the client's engagement with their experiencing and moving forward.

So by all the criteria described above, focusing-oriented therapy is certainly included in the person-centred 'family' of therapies, but we find that individual practitioners have licence to operate outside the acceptable boundaries if they so choose.

Process-experiential psychotherapy/emotion-focused therapy

The key figures in the development of process-experiential psychotherapy are Laura North Rice, Leslie Greenberg and their associates in North America (for more on Greenberg's work, see Chapter 17). We find the origins of the approach in the work of Rice (1974) when she asks the question 'what are the mechanisms of change?' (p. 294). Rice set the tone of the process-experiential project in the same chapter, an ethos evident today in the latest work (Elliott, Watson, Goldman, & Greenberg, 2004a), when she declared 'Spinning theories is not simply a luxury to be indulged in during the intervals of doing therapy by the seat of one's pants' (Rice, 1974, p. 294). Inspired by Rogers' early emphasis on research (see, for example, Raskin, 2004; Rogers & Dymond, 1954) process-experiential theorists have also led a wide range of innovative research initiatives over the last 30 years (Elliott, Greenberg, & Lietaer, 2004b).

Originally strongly influenced by Gendlin's discoveries concerning the importance of experience as a process, process-experiential therapy quickly broadened its horizons to integrate influences from a wide variety of sources from gestalt therapy to cognitive/information-processing psychology. Close observation and innovative research led to the building of theory that Elliott and Greenberg (2001) summarized as being built on:

- the humanistic values of self-determination, the primacy of experiencing, lifelong psychological development, pluralism, egalitarianism, holism and authentic person-to-person relationships;

- Greenberg's emotion theory (Greenberg & Paivio, 1997);
- a dialectical constructivist theory of self and change;
- empirically supported methods;
- a process orientation, that is, an emphasis on the unfolding of moment-to-moment process within the client's and therapist's experience and within their relationship.

In their 2004 publication, Elliott et al. present a comprehensive workbook presenting practice based on theory generated by research. The title *Learning Emotion-focused Therapy* charts the continuing development of the conceptual framework of this approach, and we find emotion-focused therapy (EFT) trainings on offer around the world (Elliott et al., 2004a).

The treatment principles and methods (explained at two levels of therapist responses and tasks), distilled through research, are described by Elliott and Greenberg (2001) as follows:

- *Empathic attunement:* actively entering the client's world anew, resonating with the client's experience as it evolves from moment to moment, and not being used as a technique to evaluate or diagnose the client.
- *Therapeutic bond:* the expression of non-judgemental genuine prizing of the client.
- *Task collaboration:* building a relationship on mutual involvement in the goals and tasks of therapy (accepting the client-generated tasks and goals and describing the emotional processes involved).
- *Experiential processing:* facilitating optimal client engagement with moment-to-moment experiencing (helping the client to work in appropriately different ways with different tasks to maximize effectiveness).
- *Task completion:* facilitating the client to complete the key therapeutic tasks identified (persisting in helping the client to stay on-task).
- *Growth/choice:* an emphasis on client agency by fostering client growth and self-determination (encouraging the client to make in-session decisions about goals, tasks and activities).

Within this protocol, the therapist might make use of specific interventions prescribed by process-experiential therapy, including two-chair and empty-chair dialogue, focusing and meaning-creation. Readers should be aware, however, that this is a snapshot of a therapeutic theory in progress, since process-experiential therapy is a developing approach as a result of a continuous research programme.

How does process-experiential/EFT psychotherapy fit into the person-centred 'family'?

Even without further explanation, it can be deduced that process-experiential therapy has a clear agenda in terms of how the relationship is to be configured, the expert role

of the therapist, the direction and progression of interventions, and the goals and tasks of the client. Although process-experiential therapy revolves around a therapeutic relationship founded on Rogers' therapeutic conditions, it extends considerably beyond the sufficiency 'rule'. It actively integrates relationship elements and techniques validated by process-experiential research, and, in Warner's terms, process-experiential therapy is self-consciously interventive at level 4. A theory and practice edifice so constructed sparks fierce debate in person-centred circles, and by any measure it challenges definitions of what might be reasonably considered to be person-centred. But is this a bad thing? Its proponents, meanwhile, frequently reassert the links with Rogers' work and continually refer to the humanistic underpinnings, the centrality of Rogers' conditions to the therapeutic process, the right of the client to self-determination, and collaboration.

Recently, Elliott (2011) acknowledged these tensions and asked whether the differences between person-centred therapy and EFT had been exaggerated, conceding that EFT jargon can put person-centred therapy therapists off because it 'makes it sound like EFT therapists are pulling levers and controlling clients'. He suggests reframing the six principles of EFT in 'more [person-centred therapy]-friendly language'. This project is both honourable and useful, since surely all therapists, regardless of their orientation, would wish to establish commonalities where they exist and not stop at the first flimsy barrier of jargon.

Encounter-oriented (dialogical) approaches

Originating in the work of philosopher Martin Buber, the idea that the human change process consists entirely in the co-created intersubjective relationship between helper and person helped is widely acknowledged in the person-centred 'family' of therapies and emerging as a suborientation in its own right. Such an approach is a tacit critique of the subjective, individual self-psychology at the centre of most interpretations of Rogers' work, and it is this strong theme that demands consideration as an approach in its own right. A dialogical approach is implicit in the recent work of Godfrey Barrett-Lennard (2004) and Dave Mearns (Mearns, 1996; Mearns & Cooper, 2005), but Peter Schmid (1998, 2001a, 2001b, 2001c, 2002a, 2006) has been foremost in elaborating dialogical therapy through the work of philosopher Emmanuel Levinas.

Schmid positions himself close to classical client-centred therapy, non-directive and espousing the sufficiency of Rogers' therapeutic conditions, but makes the *encounter* between the helper and the helped much more than a mere conduit for helping ('encounter' being different from 'relationship'). In a sophisticated series of propositions, encounter-oriented dialogical therapy plays on moment-to-moment interdependent meanings of 'self', 'other' and 'meeting' in the encounter. It is very difficult to summarize these given the space allocated here, but this could be understood as appreciating all of the potentials made possible in the separateness of the Other anew in every moment of meeting. This acknowledgement of the Other means

that the therapist approaches the client as a naïve seeker, open to whatever the Other has to offer. Schmid further elaborated this approach by introducing the concept of different forms of resonance (Schmid & Mearns, 2006).

It may be the case that, in practice, an encounter-oriented therapist might look very much like a classical client-centred therapist but bring a very different repertoire of sensibilities. One of the many consequences of such an ethos is an appreciation of human beings as necessarily social and creative. The individual, understood as 'self-first' is no longer centre stage. The Other and the co-created moment between Thou and I lies at the core. A further consequence is that this approach emphasizes the social context of therapy and thus emphasizes the value and rich possibilities of group therapy (see Chapters 5 and 13).

How do dialogical approaches to psychotherapy fit into the person-centred 'family'?

Setting aside the historical emphasis on individual, subjective self-psychology, there are no differences of any substance between classical client-centred therapy and the emerging dialogical therapy. Only through facing the Other and appreciating their uniqueness can a person be free to actualize their potential. Anything else would effectively constitute a limiting condition of worth, either acted out or implied by our personal philosophy. Such implications are powerful precursors of real behaviour and are why dialogical therapists would pay particular attention to their deep understanding of what it is to be human.

Pre-Therapy

Although Garry Prouty himself specifically refers to his work as not a therapeutic approach per se but as pre- (coming before) therapy, it deserves a brief introduction in this review (Prouty, 1994; Prouty, Van Werde, & Pörtner, 2002). Prouty was the first person to make a serious study of psychological contact. His work confirmed Rogers' early hypothesis that therapeutic change cannot take place without psychological contact and developed a conceptual and practical system for understanding and establishing contact with people whose ability to make contact had been impaired by illness or injury, whether organic or psychological. The range of applications (still growing) includes clients who are contact-impaired as a result of age-related and other forms of dementia, brain injury, terminal illness, 'psychosis', dissociation, severe learning disability or autism.

Prouty describes Pre-Therapy as 'applied phenomenology' and explains its action as 'pointing at the concrete'. Through irreducible 'contact reflections' (extremely simple reflections regarding verbal and facial expressions and the shared reality of the environment), the client is brought back into contact with their experience, other people and the world. When contact and everyday functioning have been restored, psychotherapy is then possible. The 'pre-expressive' self (the person previously trapped

inside) is now able to choose to take part in everyday human relationships, and some of the secondary symptoms of chronic isolation dissolve. Thus, some take the view that Pre-Therapy is in fact a genuinely therapeutic intervention in its own right, as well as being an essential precursor to therapy with contact-impaired individuals.

Although it might appear simple to describe, Pre-Therapy is not, however, easy to do. Most trained therapists have great difficulty in stripping away the finer aspects of therapeutic communication to get to the bare bones of applied phenomenology that are required for successful contact work.

How does Pre-Therapy fit into the person-centred 'family'?

There can be no doubt that Pre-Therapy is closest to the core of classical client-centred therapy in practical terms. It is vital to remember, however, that it is not a 'normal' human relationship in the strict sense – it is a way of being for special occasions. Its essential protocols are derived from the need to make the most basic of relationship moments with another human being and so are incomparable to other applications of Rogers' work. Yet Pre-Therapy is without doubt one of the purest incarnations of person-centred communication (see Chapter 22).

Motivational interviewing

In 1983, William Miller, an American psychologist specializing in alcohol and substance abuse and addictions, described an approach that quickly developed into what is now known as motivational interviewing (Miller, 1983; Miller & Rollnick, 2002). The original writings make it clear that it is rooted in Rogers' client-centred therapy:

> We regard the therapeutic skill of reflective listening or accurate empathy, as described by Carl Rogers, to be the foundation upon which the clinical skilfulness in motivational interviewing is built. (Miller & Rollnick, 2002, p. 37)

The 'twist', however, is that motivational interviewing, while 'client-centred', is quite self-consciously directive in that it has the particular purpose of working with clients to crystallize the issues that are holding them back from making a positive change in their lives and then directing them towards *making that change*. Miller and Rollnick are clear that they do not advocate 'using reflective listening simply to follow people wherever they happen to wander' (Miller & Rollnick, 2002, p. 38). So empathy is used instrumentally and neither does motivational interviewing mention the other therapeutic conditions. It is a therapeutic approach inspired by Rogers' demonstration of the efficacy of empathy but then departs quite intentionally from other person-centred protocols.

It is an approach developed for clients with problems of addiction (see Chapter 25) and addresses the stumbling block in therapy when clients cognitively accept all the reasons for making a change but are unable to motivate themselves. Recently, the approach has sought to generalize its application to other areas of life change.

How does motivational interviewing fit into the person-centred 'family'?

Simply put it, it occupies a marginal position at best. Motivational interviewing practitioners are drawn from therapeutic approaches across the board, and motivational interviewing is a post-qualification tool for anyone specializing in addiction. Its client-centred roots can soon be lost in technique. A client-centred therapist might struggle to practise motivational interviewing, with its directive injunction, but, for example, a cognitive therapist would feel quite at home.

Modalities

There is no space to do more than list the various therapeutic applications of classical client-centred, person-centred, focusing-oriented and process-experiential therapies. It is important for readers to realize that there are no theoretical or practical limits (save the imagination of the therapist) that would limit the application of this 'family' of therapies. Readers are directed to other chapters in this book and, among others, to the work of the following innovators in their respective fields: for example, child psychotherapy (Moon, 2002), couple therapy (O'Leary, 1999; see Chapter 19), family therapy (Gaylin, 2001; see Chapter 19), expressive arts therapies (N. Rogers, 1993/2000; see Chapter 16) and group therapy (Hobbs, 1951; Raskin, 1986a/2004, 1986b/2004; Shlien, 2003; see Chapter 15).

Conclusion

If the terms 'person-centred' and 'client-centred' have become too general and lacking in discrimination, new descriptors are necessary. And it is possible that this list of new names continues to grow, even as I write, and certainly more variations will have been added by the time this book is published. So, reconciled to be forever one or two steps behind, I hope I leave readers better able to make decisions about the newest types of therapy claiming to be inside, or just outside, the big tent of the person-centred approach.

Readers hitherto unfamiliar with the various strands of development of client-centred therapy since 1960 may by now feel a little overwhelmed. Today the fashion is to be 'beyond schoolism', so they might well ask why the client-centred community seems hell-bent on diversification rather than unification. In addition, they might despair that such divergence might lead to conflict. It is my view, however, that the apparent proliferation of 'brands' is not competitive in nature; rather it is descriptive.

Obtaining a better understanding of what therapists do is an ongoing process of the description, refinement and development of ideas in which all therapists should engage for the sake of their prospective clients, for fellow professionals and for themselves. No therapist is beyond refining their understanding and description of their own practice, and we all have much to learn from the work of others.

Points for reflection

- Do you think that the important task for person-centred therapy in the twenty-first century is to protect the pure form of the approach or to develop and embrace new ideas?
- In terms of practice, are clients best served by therapists who are prepared to integrate ideas and interventions from philosophically sympathetic sources or those who stick strictly to the necessary and sufficient conditions?
- What would be your definition of person-centred therapy, and what criteria would you use to determine its boundaries?

Key readings

- Kirschenbaum, H. (2007). *The life and work of Carl Rogers*. Ross-on-Wye: PCCS Books.

For readers wanting a biography of Carl Rogers with an extended review of developments after his death.

- Sanders, P. (Ed.) (2012). *The tribes of the person-centred nation: An introduction to the schools of therapy related to the person-centred approach* (2nd ed.). Ross-on-Wye: PCCS Books.

Documents the history and development of the families of person-centred and experiential therapies in an accessible way for beginning trainees.

- Tudor, K., & Worrall, M. (2006). *Person-centred therapy: A clinical philosophy*. Hove: Routledge.

A comprehensive and scholarly analysis recommended to all students of psychotherapy.

- World Association for Person Centered and Experiential Psychotherapy and Counseling.

Students and practitioners of person-centred and experiential therapies will find valuable information, scholarly discourse and rewarding networking opportunities as members of the Association. In particular, the peer-reviewed, indexed journal *Person-Centered and Experiential Psychotherapies* charts developments in theory and practice (www.pce-world.org).

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5
The anthropological, relational and ethical foundations of person-centred therapy

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This chapter discusses:

- The image of the human being underlying the person-centred approach
- Key concepts for understanding the person-centred endeavour: 'person', 'encounter', 'dialogue' and 'presence'
- The consequences of this model of the person for the individual and relational dimensions of person-centred therapy, including group therapy
- Therapy as a primarily ethical enterprise

The importance of the reflection on the image of the human being

Each human being bases their acting and thinking – consciously or not, reflected or not, scientifically (that is, systematically) investigated or not – on assumptions of what and how people are. We all have an image of ourselves and the human being in general that constitutes our 'anthropology', that is, our understanding of us as humans. We all have conceptions: why we act and think in a specific way and not in another one (theory of motivation), how we develop and change (theory of personality), how we relate to others (theory of relationship), how and

why processes occur that make us suffer or unhappy (theory of 'disorders') and how we can help each other, or generally influence each other (theory of therapy) (see Chapters 2, 7 and 8 and Part II).

Our living and thinking is founded in basic beliefs, in a more or less consistent image of the human being as part of our worldview. Beliefs about the nature of the human being cannot be verified or falsified. Therefore it does not make sense to argue about different images of the human being or to try to convince each other of them.

Theories of psychotherapy are different because the underlying image of the human being, the anthropology, is different. Therefore there are different schools of therapy. The so-called humanistic and existential orientations in psychotherapy are the only ones which have so far explicitly taken the image of the human being as a starting point for practice and theory-building. The anthropological, epistemological and ethical convictions of the humanistic image of the human being were summarized in the form of theses by James Bugental (1964), in what is called the 'Magna Charta' of humanistic psychology. Among them are the statements that the human being supersedes the sum of their parts (a holistic perspective including 'body', 'soul' and 'mind'), that they live consciously, and that they have the free will to decide and live towards aims. An important conclusion of such assumptions is that a science adequate for the human being, namely a *human* science as opposed to a *natural* science (hence named 'humanistic'), is still to be developed.

Humanistic psychotherapy is the practice resulting from this image of the human being. This marks a profound revolution in psychology and psychotherapy, a true change of paradigms, not yet fully sounded out. The individual who has thought this through most fully, implemented it in practice and is probably the most influential figure of the humanistic thinkers is Carl Rogers; and the philosophy, theory and practice that radically adheres to this image of the human being is that of person-centred therapy. (For sources of, and influences on, Carl Rogers' image of the human being see Chapter 4 in the first edition of this Handbook.)

Person: the human being's autonomy and interrelatedness

The 'person-centred' approach is called after what, in the history of occidental (Western) philosophy, became known as *the* term for a view of the human being as described by the humanistic authors: the human being as a *person*. Even if the name of the approach may first have originated for pragmatic reasons (to find a comprehensive term for possible new fields of application beyond clients), Rogers deliberately chose it because of its essential meaning (Kirschenbaum, 2007). This meaning, meanwhile thoroughly analysed in dialogue with encounter and existential philosophy and phenomenology (see Schmid, 1991, 1998a, 1998b, 2001/2002 for details and references), has far-reaching consequences for our understanding of ourselves and our fellow humans. And it is through the understanding of this term and those related to it that the truly humanistic image of the human being underlying all of person-centred theory and practice can be profoundly understood.

To view the human being as a person combines two inescapable dimensions of human existence: the substantial (or individual) aspect of being a person and the relational (or dialogic) aspect of becoming a person. These two strands can be found throughout the history of occidental philosophy.

Independence

The *substantial conception* emphasizes independence and uniqueness, freedom and dignity, unity, sovereignty and self-determination, responsibility, human rights and so on. That is what is meant when the human being is defined as a person, starting from the moment of conception and regardless of their physical or mental health and development. Being a person therefore means being-from-oneself and being-for-oneself ('sub-stantial').

This conception of the person is especially influential in the (early) period in Rogers' thinking during which, based on the actualizing tendency, he mainly understands the human from the individualistic point of view and consequently sees therapy as a process of the development of personality (Chapter 8), with its emphasis on confidence in the organism, a realistic self (Chapters 6, 7) and, above all, positive regard (Chapter 12) and empathy (Chapter 11) as beneficial conditions. As an ideal notion of the mature human being, Rogers coins the phrase 'fully functioning person' (Chapter 6). Beyond this, the substantial dimension is mirrored in concepts such as the person as a self-determined (and thus responsible) individual, the actualizing tendency (Chapter 6), trust in the organism, experience, self and self-actualization, symbolization, authenticity as congruence between experience and self (Chapters 6, 7 and 13), incongruence as central factor of 'dis-order', presence as awareness (Chapter 14), and the Other.

Interdependence

The *relational notion* of the person highlights relationship (Chapters 10 and 14), dialogue, partnership, connection with the world, interconnectedness and community (Chapters 15 and 32). Hence, being a person means being-from-and-in-relationship, that is, being through and towards others. We are not only *in* relationships – as persons, we *are* relationships.

This conception of the human as a person particularly characterizes Rogers' later phases, where he understands people as being relational, in a group (Chapter 15) and in community (Chapter 32), as 'person to person'. Consequently, mutual encounter is a decisive element in therapy and personal development, and Rogers now considers genuineness (Chapter 13) as a pre-eminent facilitative condition. The relational dimension is mirrored in concepts such as the person as process ('becoming a person'), encounter, presence as openness to others, authenticity as congruence between experience and communication, unconditional acknowledgement, empathic understanding, immediacy, context, group, community and society: the person-centred approach as a '*way of being with*'. (For more details, see the first edition of this Handbook and Schmid, 1991, 1998b.)

A substantial-relational being

Both of these ways of understanding the human being are contrary, even conflicting, yet it is exactly this tension of self-reliance and commitment, sovereignty and solidarity, that uniquely characterizes being human. Both are radically taken seriously in the person-centred approach. It can clearly be shown that the meaning of 'person' in the original and genuine person-centred context precisely refers to these two dimensions, which may be characterized by the terms 'actualizing tendency' and 'fully functioning person' on the one hand (see Chapter 6), and 'encounter', 'dialogue' and 'presence' on the other. Furthermore, this anthropological stance, well elaborated by phenomenology and personalistic philosophy, is the distinctive characteristic of person-centred understanding and action. Only in the dialectic of both interpretations, not in an 'either-or' but in a 'both-and', does the mystery of the person become accessible to whoever allows themselves to become involved in a relationship from person to person (Box 5.1). A conception gained from these two perspectives of the person contrasts with a privatistic (seclusive, apolitical) conception of the human being just as it does with a collectivistic one.

Box 5.1

The basic *dialectical* axiom

In person-centred anthropology, the basic dialectical axiom is the actualizing tendency – as the force of the individual – embedded in the interconnectedness and social nature of the person. Both strands of the axiom form the foundations of the understanding of personalization – of authentically 'becoming a person' (Rogers, 1961). It is important to be aware that self-determination *and* interrelatedness refer essentially to one and the same human nature, although we may view and experience these as different dimensions. *To regard the human as a substantial-relational being is what is meant by designating them as a person*. Authenticity is the process of balancing individuality and interrelatedness. This includes becoming the author of one's own life in responsibility: responsibility understood as response-ability to oneself and to others.

Nevertheless, contact and relationship were a central category of Rogers' anthropology from the very beginning (cf. Schmid, 2001/2002) and the formulation of 'The necessary and sufficient conditions of therapeutic personality change' (Rogers, 1957) could never have taken place without it. Already, the first condition refers here to contact and the second to communication – a relational foundation (see Part II).

All in all, Rogers combined both views in a unique way for psychotherapy when he built his theory and practice upon the actualizing tendency, which is at work at its best in facilitative relationships of a certain kind (see below). Person-centred

personality and relationship theory understands personalization as a process of becoming independent *and* of developing relationships.

It is certainly no coincidence that Rogers repeatedly referred explicitly (see, for example, Rogers, 1961) to two philosophers to whom the history of the conception of the person has always accorded a position of prime importance: Kierkegaard, who considers the misery of the individual, and Buber, who points out the opportunity implied by dialogue.

Encounter: the acknowledgment of the otherness of the Other

As early as 1939, Rogers wrote in the context of child guidance that 'the relationship between the worker and the parent is the essential feature' (p. 197). Although Rogers was convinced from the very beginning that 'the interpersonal relationship' is 'The core of guidance' (1962a), only later in the development of both Rogers and person-centred therapy was more emphasis laid on the relational dimension, until Rogers (1965, p. 20) clearly stated that the nature of the human itself is 'incurably social'. This led to a considerable development in the understanding of the therapeutic endeavour as far as the client–therapist relationship as a relationship of person-to-person is concerned. It also led to significant progress in the appreciation of group therapy and the social dimension of therapy and counselling (see below and Chapter 15; see also Chapter 10 in the first edition).

Consequently, Rogers (1962b) finally came to explicitly understand therapy as *encounter*. With this term, he characterized psychotherapy as a form of a particular way of relating between human beings, namely from person to person – well known as a key term in encounter philosophy as the only adequate way of meeting, acknowledging and understanding a human being as a person. Again, to understand what this means for counselling, it helps to become familiar with the anthropological implications and consequences (for details and further references, see Schmid, 1994, 1998a, 1998c, 2000, 2001/2002, 2002a).

Being with and being counter

One of the consequences of viewing the human being as a person is the realization that accepting another person means truly acknowledging him or her as an Other. He or she is no alter *ego*, no close friend a priori, no identifiable person, but rather an entirely different person. Only when fully appreciating this fact of fundamental difference do encounter and community become possible. Etymologically, the word 'encounter' comes from Latin 'contra' which is 'against' (Schmid,1998c). To en-*counter* another person first of all means recognizing that the Other really 'stands counter', because he or she is essentially different from me.

The German philosopher *Romano Guardini* (1955) defined encounter as an amazing meeting with the reality of the Other: encounter means that one is touched

by the essence of the opposite. In order for this to happen, there must be a non-purpose-oriented openness and a distance that leads to amazement. So encounter is always a risk, an adventure that contains a creative seed, a breakthrough to something new. For an interpersonal encounter, this means that both affinity and alienation can be experienced at the same time.

The theologian *Paul Tillich*, with whom Rogers entered into an open dialogue (Rogers & Tillich, 1966), pointed out that the person emerges from the resistance (that is, the being-counter) in the encounter of the Other: if the person

> were not to encounter the resistance of other selves, then every self would try to take itself as absolute. … An individual can conquer the entire world of objects, but he cannot conquer another person without destroying him as a person. … If he does not want to destroy the other person, then he has to enter into a community with him. It is through the resistance of the other person that the person is born. (Tillich, 1956, p. 208)

'Being counter' is, according to *Martin Buber* (1974), the foundation for meeting face to face. To be opposite to the Other offers the possibility to face and to acknowledge them. According to Buber, being a person consists in the event of encounter or dialogue, of communicating oneself. He defines encounter as the immediacy of the I–Thou relationship, an event in which one becomes present to the Other. The I is not constituted until such an encounter relationship: 'The I becomes through the Thou. Becoming an I, I say Thou. … All real life is encounter' (Buber, 1974, p. 18). Therefore encounter is where dialogue happens (see below).

To stand counter also means to give room to each other and to express respect. In facing the Other, I can acknowledge the Other's uniqueness and qualities. *In facing Others, I do not think what I could know about them ('diagnosing'), but I am ready to accept what they are going to disclose ('empathic listening with unconditional positive regard') – with far-reaching consequences for therapeutic epistemology (see below).*

From I–Thou to Thou–I

The French existential philosopher *Gabriel Marcel* (1935) emphasizes that the Other has always been there in advance. Similarly, but much more radically, the Lithuanian philosopher *Emmanuel Levinas* (1961, 1983) lays emphasis on the priority of the Other, the truth (both phenomenologically and developmentally) that the Other always comes first.

He points out that all of the Occidental philosophy has remained 'egology.' (This also applies to psychology as philosophy's 'daughter' and to psychotherapy as its 'grand-daughter', including its so-called humanistic orientation in the twentieth century. This fixation on the 'I' is clearly predominant in the terminology of those forms of humanistic psychology that are only concerned with self-development.) Despite all positioning against an objectivism and instrumentalism, such approaches end up reducing the Other to what the Other means to me. (In this connection, even

Buber's 'I become through the Thou' suddenly sounds quite different: even here, as is to be suspected, everything is still focused on me.)

In his main work *Totality and infinity*, Levinas (1961) illustrates that to exist means to be entangled in oneself, caught in the totality of one's own world. Accordingly, the first alienation of the human being is not being able to get rid of oneself. The awakening from the totality of the being-caught-in-oneself does not happen through 'being independent'. Rather, the Other is the power that liberates the I from oneself. The foundation of self-confidence is not the reflection on oneself but the relationship to the Other. This overcomes the limits of the self: the self is born in the relationship to another person.

In the same context, Levinas uses the metaphor of 'visage' ('that, which is seen', that is, the face) to characterize the Other. This face addresses us, speaks to us, even demands and challenges us. The Other – who is absolutely different, and thus not to be seen from my perspective – is the one coming towards me, approaching me. The Other 'enters' the relationship – what Levinas calls a 'visitation' (that is, 'going to "see" somebody'): my look is touched by the look of the visage. *The movement goes from the Thou to the I*. Accordingly, the fundament of self-consciousness is not the reflection of the I through the Thou but the experience of relationship (Levinas, 1983), which marks a shift from the 'I–Thou' relationship to a 'Thou–I' relationship (thus managing to get closer to the verge of the underlying 'We'; see below). In addition, from a developmental perspective, the movement always originates from the Thou: it is the call, the addressing of another human being, which evokes a response, confronts with freedom and risk. Encounter happens to a human long before they can aim at obtaining such an experience.

Thus, encounter in dialogue turns out to be a condition for self-consciousness, a common transcendence of the (totalitarian) status quo, a start without return (an 'in-finity'). In other words, encounter is always a challenge: 'Encountering a human being means being kept awake by an enigma', states Levinas (1983, p. 120).

The relational turn in psychotherapy

Many schools of psychotherapy, at the forefront a contemporary person-centred perspective, favour a much more relational view (Schmid, 1994, 1996a, 1998c, 2006b; see also Haugh & Paul, 2008; O'Hara, 1992, 1997; O'Hara & Wood, 1984; and the overviews and lists of authors in Schmid & Mearns, 2006, and Barrett-Lennard, 2007).

Godfrey Barrett-Lennard (2005, 2007), proponent of a 'client-centred relational therapy', elaborated and contributed to the development of an understanding of human life as an inherently relational process. He wrote convincingly about the need for the healing quality of relationship in a troubled world, from inner and family life to international relations, based on the conviction 'that relationship is emerging as a serious focus in the human sciences' (2005, p. 131; see also Chapters 8 and 32).

To understand psychotherapy relationally as an encounter and as a dialogue between persons is increasingly accepted within the contemporary person-centred field and in many other orientations. This is a consequence and genuine development (independently spearheaded by Schmid [1994, 2002b, 2002c, 2006b, 2013; Schmid & Mearns, 2006], Barrett-Lennard [2005], Mearns & Cooper [2005] and others) of the phenomenological and humanistic foundations of the person-centred approach – faithful to Rogers' anthropological and epistemological positions, which in many ways turned out to be more radical than he himself was aware of.

The person is dialogue

More and more in recent years, the name 'dialogical' has appeared to describe the theory and practice of this viewpoint, although with different meanings. Such an approach finds its foundations in the further developed stages of dialogic philosophy. On an existential, fundamental level, dialogue is much more than a mutual exchange as we are used to thinking of it. Dialogue, in this view, is not the goal or outcome of a personal relationship (for example, in therapy in its later stages) or moments of intensive mutual interchange. Rather it is to be seen as an ontological given, an existential pre-condition of human living (Levinas, 1989). Human beings, understood as persons, are not only *in* dialogue; they *are* dialogue (Schmid, 2006b, 2013). Humans have a choice 'to enter', to 'go into', to get involved, let themselves in for the given dialogue or not. To enter means to be in accordance with it, to correspond and correlate, which is a process to unfold but not something to be 'made' or 'constructed' or achieved by certain rules or techniques. Dialogue is an 'underlying' form of existence, which can be allowed to manifest itself or be blocked from manifesting.

This is true for psychotherapy as well. If dialogue is there in the beginning, it follows that, in therapy, client and therapist are in dialogue from the very first moment of coming-together (Box 5.2). Their task is to 'enter' this already given dialogical interpersonal situation and to unfold its power for a facilitative development of the client, and often also for the therapist. For the therapist, it is important to be aware of the Thou–I in this relationship, that is, genuinely to encounter, to be surprised by the otherness of the Other.

Psychotherapy, then, is the unfolding of dialogue. Therefore dialogue is not a consequence, but a fundament of community. It is about realizing the preceding, *fundamental common We* (Schmid, 2001/2002, 2003, 2006b) – in all its dissymmetry. *Therapeutic dialogue is realizing the healing and challenging quality of the essential human We*. The *restoration of this underlying We is the therapeutic in psychotherapy*. This is done by presence as the realization of the core conditions (see below). Hence presence is not a precondition for dialogue; rather, it is dialogue that comes to the fore in presence.

Box 5.2

A process of co-creating the therapeutic venture

Taking the person-centred image of the human being seriously, person-centred therapy must be seen as *a bi- (or multi-) polar model of psychotherapy*, in which both (or all) persons involved are in the focus of reflection.

Accordingly, encounter is the core of an *intersubjective, co-creative process of personalization* (that is, becoming a person) through meeting (Mearns, 1996; Schmid & Mearns, 2006) based on the idea of the self-organizing wisdom of the person (Bohart, Held, Mendelowitz, & Schneider, 2013).

The nature of therapy is to co-respond to the situation the client finds themselves in. This also means the therapist and client are co-responding to the relationship they find themselves in the very moment of their being-together. So they are co-creating the relationship out of mutual encounter. The client's contribution to this fundamentally dialogical process is to gradually realize their potential as a self-helper and actively make use of their inherent capacity to make the acknowledgement and empathy of the therapist work (as is explained by Bohart in Chapter 6; see also Bohart, 2004; Bohart & Tallman, 1999). The contribution on the therapist's part for entering into the dialogical encounter is to be present (see below).

A dialogical approach in person-centred therapy, as developed by Schmid (1994, 1996a, 1998a, 1998c, 2006b, 2013) and others, that emphasizes or even rests completely on dialogue 'is different from the "traditional" phenomenological approach of client-centred therapy wherein we look at the separate experiences of the therapist and the client. A dialogical approach is concerned with the "between"' (Sanders, 2007, p. 112). This is grounded in the conviction that therapy 'needs to be based *on and in* dialogue and that the "goal" of therapy is the enhanced relational ability of the client – summarized by the phrase "healing through meeting"' as Sanders (2006, p. 111, emphasis added) states – whereas healing in the person-centred therapy always means personality development.

On closer examination, it can be found that much of this was already implicit in Rogers' work, many things even from the very outset. Let me give some examples here. The acknowledgement of otherness that is crucial for a true encounter-oriented view of psychotherapy is already implicit in Rogers' basic concepts of the centrality of empathy, unconditional positive regard, active listening and non-directiveness: with these terms, Rogers took a clear stance on how to approach another individual adequately as an Other. Another example is the discovery of the parallel of Rogers' individualistic-relational view of the person and the respective strands in philosophical anthropology. A third case is the understanding of the therapist conditions as dimensions of one central 'way of being with', that is, presence (see below).

Relational depth

Building on this philosophical turn towards a fundamental relational understanding of the human being outside and within therapy, Dave Mearns and Mick Cooper (2005) have developed and explored the concept of *relational depth*, initially described by Mearns in 1996. They argue that many forms of psychological distress may have at their root a lack or even absence of in-depth relating. Mearns and Cooper (2005, p. xii) describe (as a 'working definition') relational depth as 'a state of profound contact and engagement between two people in which each person is fully with the Other, and able to understand and value the Other's experiences at a high level'. They underline that they use the term 'to refer both to specific *moments* of encounter and also to a particular *quality* of a relationship'. Their primary focus is on 'encountering the client in an in-depth way and sustaining such a depth of relating' (p. xiii), which they see as the key to psychotherapy, thus overcoming the idea that therapy might be the provision of a particular set of conditions. The therapist's experience of meeting at relational depth is characterized as 'a feeling of profound contact and engagement with the client, in which one simultaneously experiences high and consistent levels of empathy and acceptance towards that Other, and relates to them in a highly transparent way' (p. 36). In encountering the client in depth, they consequently follow Rogers' intention and 'put the core conditions together again and emphasize their power in combination' (Mearns, 2007, p. 23).

This is tremendously important in order to overcome a behaviour-oriented, technique-oriented or therapist-oriented ('which conditions must I provide?') understanding of person-centred therapy, a stance that views the so-called core conditions as descriptions, or even prescriptions, for parts of the actual therapist behaviour.

The concept of relational depth also stresses the necessity for the therapist to meet the client as a unique, genuine human being, and therefore the importance of the realness of the therapist in order to allow an encounter to take place, 'a meeting that is fundamentally "counter" to the self' (Mearns & Cooper, 2005, p. 42) and can enable a corrective relational experience for the client and give hope of overcoming loneliness by feeling deeply understood and prized, an experience that can foster trust and the development of the client's confidence in their own capability of building sustaining relationships. Such an understanding of the therapeutic relationship as a genuinely profound human engagement with each other goes far beyond a more or less superficial alliance or a 'use' of relationship to help any therapeutic agenda to proceed.

The concept of relational depth had an enormous impact on the practice of many therapists, particularly in Britain, and also those working beyond the person-centred orientation. (For further explorations of the concept of relational depth, see Knox, Murphy, Wiggins, & Cooper, 2013.)

Presence instead of 'practising techniques'

Whereas Rogers discussed the concept of *presence* as a possible fourth basic condition, Schmid (1994, 1996a, 2001/2002, 2002a) was able to show that presence is the exis-

tential foundation and deeper meaning of the well-known, yet all too often superficially misunderstood, therapist conditions of authenticity, acknowledgment and comprehension (to use Buber's philosophical terms, which widely coincide with Rogers' basic attitudes). The underlying Latin verb *praeesse* means 'to be fully there'. To be present means that the therapist's task is to ever anew try to realize the conditions continuously and in any given situation – thus responding to the challenge of the relationship in its concrete context (cf. Geller & Greenberg, 2002; Thorne, 1991; see also Chapter 14).

Among other things, this implies that that the therapist does not 'impose' either preconceived techniques or an abstinent attitude. It rules out that the therapist considers themself to be an expert in the correct usage of methods and means, and even excludes any use of methods and techniques that is not rooted in the immediate experience of the relationship. The only 'means' or 'instrument' employed is the person of the therapist themself. Only where 'every means has fallen apart' does encounter take place, as Buber (1974, p. 19) has stated – unsurpassably and precisely also grasping the process of such a relationship. Therefore, '*im-media-cy*', a favourite term of encounter philosophers, is an important characteristic of person-centred therapy. Consequently, therapists cannot regard themselves as the experts on the client's experience or on the contents or means of the therapeutic process; on the contrary, the client is the expert – it is this emancipatory stance that holds the enormous subversive potential of person-centred therapy. (For more on the client's expertise, see Bohart & Tallman, 1999.)

All in all, this is the foundation for an *epistemology* that is completely opposite to the traditional psychotherapeutic theory of knowledge: the movement does not go from me to the other individual – as is the case with traditional diagnosis, where the therapist as the expert 'examines' the other to see which frame fits, what can be observed. Instead, the question is what the other as truly being an Other shows, discloses, reveals. This means that I cannot simply conclude from me and my experience to the self and experience of the other person. The attitude, rather, is to open up and genuinely accept and empathically try to comprehend what the partner in the relationship is going to disclose. In a nutshell: to understand is to listen, to realize is to appreciate, to become aware of is to follow (and not to direct – hence the 'non-directiveness', to be understood as facilitative responsiveness; see Chapter 2 and Schmid, 2005), Thus the relationship, also in psychotherapy, must correctly be named a *Thou–I relationship*, because it has its origin in the opening up of the 'Thou' (for references and details, see Schmid, 2001/2002, 2003, 2004).

This completely coincides with a phenomenological and existential stance (see Chapter 7) and an ethical posture that can be seen as both the consequence and the foundation of person-centred anthropology (see below, on ethics).

The group: interface of person and society

From both our experience and from encounter philosophy, we know that there is not only the (one) Other. There are many Others. And there is not only the relationship

between the Other and me, but there are relationships between the Others, too. In other words, the relationship between two single persons is always embedded in a network of relationships: humans live in groups.

What is a group? Does a gathering of individuals form a group, making it a secondary, dependent variable; or is the group there first and the individuals second, formed by and developed from the group they live in? For many people, the question of what is primary, the group or the individual, may seem a bit like the chicken and the egg debate. But for the understanding of the person and their problems as well, as for therapy, it has deep theoretical and practical implications, offering as it does a way of viewing human existence that transcends the dualism of Western thought while maintaining a sense of a sovereign personhood.

Human beings generally live in groups; the 'natural' and, in this sense, original living arrangement of human beings is the group. In terms of developmental psychology, the group provides the context in which human beings experience life, whether in a family, at school, at work, in social interest associations, and so on. In all those contexts, one-to-one situations are the exception, groups are the rule. Even pair relationships usually exist as part of a group, embedded within it. Human beings are born into groups – at least as a rule. It is within groups that we discover our identity. Through them, we know who we are and where we belong (for references, see Schmid, 1996a, pp. 57–76).

The primary manifestation of humanness, then, is not the individual but the human being together with other human beings. The human being is a social being and, from the very beginning, is predisposed by his or her very corporeity to communicate with the world and with human beings. On a purely biological level, the human being originates in a human relationship. That the human is primarily a social being is not just true in terms of the human's needs but in their very essence. This is also true for epistemology: human knowledge is not possible without human society. Body, awareness, sociality, values, language, communication – none of these would exist without community. The human world is always a world of interactions. Human existence is coexistence.

From this relational, sociocentric, or holistic perspective, the group is far from being merely a gathering of individuals or an extension of the 'one-to-one relationship'; rather, it is a primary social fact. It is a place where persons experience their selves-in-relationship (that is, themselves in their social and individual qualities), and it is also their connection to larger social communities and to society and humankind as such. A group constitutes both the persons belonging to and participating in it, as well as having its own autonomous existence as a social entity, which in turn is connected to and participates in other groups within the broad social context. In this fashion these interconnected groups are contributing parts of the greater whole that constitutes the totality of society.

The group exists at the interface of individual and society; therefore it is *the* field for both personal encounter and mutual exchange within society. Thus, a group is neither a mere collective nor is it the sum total of its members, but a complex social

system, an entity of its own, existing in a state of tension between person and society, a process in which individual and collective realities become clear and subsequently influence each other in many different ways (Schmid, 1996a, p. 72). In other words: 'The individual creates the group which creates the individual' (Wood, 1988, p. 245, author's translation).

The most cogent substantive argument in support of the group as a primary reality comes from the person-centred approach itself. As already outlined, the human being is and becomes a person within their interpersonal relationships where they actualize their personhood; more exactly, it is within groups that a human being becomes a person. Carl Rogers (1965, p. 19f) stated that 'human beings are incurably social', 'social animals' (Rogers, 1961, p. 103). In overcoming the isolated I–Thou relationship, the person-centred approach regards interpersonality as being founded in the above-mentioned fundamental 'We' (Schmid, 1996a, pp. 521–40, 2003). The group is the arena for personal encounters in the context of the bigger community or society – with far-reaching consequences for any political agenda of the therapist (see Chapter 32). And thus it follows that one should consider a 'therapeutic primacy' for group therapy. (For more on groups, see Chapter 15; see also O'Hara, 1997; Schmid, 1996a, 1996b, 2001/2002).

Ethics: therapy as a Thou–I relationship

Rogers elaborated his approach out of his experiences in relationships. What Rogers observed in therapies and from whence he drew his hypotheses were not indifferent data but personal experiences; his approach came out of being touched and moved personally. This means that his theories imply a distinct value judgement, and the same applies to psychotherapy as such. By doing psychotherapy and by reflecting this theoretically, a decision is made to respond to the misery, to the grief, to the need, to the life of another person – to share their joys and sorrows. It derives from being addressed by the Other, from being touched, from being asked, being called, from being appealed to, from a demand. This means that the need of the Other is there first and that psychotherapy is responding, answering, to this demand. Thus, all psychotherapy takes its origin at the Other. It sees him or her as a call and a provocation.

If the point is that the other is an Other on principle, this means that he or she is somebody who is strange (Schmid, 2011) to me, who surprises me and whom I have to meet with the respect of not-knowing and acceptance. The fellow being is the one whom I am opposed, face to face, and whom I have to face – neither monopolizing nor rejecting them. Since the presence of the Other always 'comes first' and is seen as a call for a response, I cannot escape because nobody can respond in my place. We are obliged and responsible to the Other and owe them an answer. As already shown, this causes the Other to become a 'priority'. The crucial point therefore is that, *starting from a phenomenological, existential and dialogical consideration, psychotherapy must be regarded as an unavoidably ethical phenomenon and enterprise*. (This must not be misunderstood in a moralistic way.

From a phenomenological and anthropological point of view, ethics denotes moral philosophy not casuistry or moralizing. Ethics means the philosophy of the challenge of living in terms of how to respond, to live respons-ibly, to live one's response-ability; details and references can be found in Grant, 2004; Schmid, 1996a, 2001/2002, 2002b, 2002c; see also Box 5.3).

Box 5.3

A way of being *for*

Psychotherapy is ethically founded. *Working as a therapist or counsellor means being asked to respond out of one's response-ability*. Response-ability is the basic category of being a person: out of encounter arises the obligation to respond. Accordingly, psychotherapy means service to the fellow person out of engagement and solidarity. The commitment towards the Other means a responsibility that originates in the basic dependency of the human being on his or her fellow beings. In ethical terms, *the 'way of being with' is a 'way of being for' another person*.

Ethically seen, each therapist has to offer what they think to be the best they can offer. If psychotherapy is understood as an encounter relationship in which the client is opening up and revealing themselves, the task of the therapist is not to try to get knowledge about the client but to acknowledge the person who is showing themselves. The therapist is the person responding to the needs of another person and is therefore responsible in the communication.

As with philosophy, essential ethical features are also implicit in Rogers' work. Taking a closer look at the core of person-centred theory, as expressed in Rogers' 1957 statement, one finds that the ethical foundation is already included here: according to Rogers, psychotherapy means responding to incongruence, to a vulnerable or anxious person. It follows that if Rogers' conditions are regarded as necessary and sufficient for a constructive development of the person by means of psychotherapy, it is an obligation for the therapist to take them into account (contact, client's incongruence, communication of therapist's attitudes) or to offer them respectively (congruence, unconditional positive regard, empathy). (For the spiritual and political implications of this, see Chapters 9 and 32.)

Conclusion and implications for practice

The considerations about the underlying image of the human being in his or her individuality and interrelatedness clearly demand a theory and practice of psychotherapy that values and builds upon both the resources of the individual and the transforming power of an encounter relationship. Thus, it is important to listen *and* to respond,

to be empathic and prizing *and* authentic, to be non-directive *and* to be engaged, to be alter ego *and* partner in the dialogue, in a word to be with the Other and to hold a counter-position to him or her; this creates a dialectical tension characteristic of the person-centred approach aiming at the actualizing process of personalization, that is, the development of the person's resources by supporting the proactive self-healing potential through an encounter relationship (Schmid, 2007; see also Chapter 6). The theory and practice of anthropology and psychotherapy has just begun to address this, and it is open for many exciting developments and discoveries yet to come – in each single therapy as well as in the advancement of psychotherapy as a whole.

Points for reflection

- What is your image of the human being? To what extent is it in line with the person-centred view described above?
- How do you deal with yourself in crises or difficult situations? Do you prefer to build on your own strengths or do you prefer to seek for help? How does this influence your attitude and behaviour when being with people in need?
- Can you identify moments of in-depth relating and encounter in your own life? Are there ways in which you can use these as touchstones for your own therapeutic practice?
- What are the considerations and criteria you would use to recommend clients for individual or for group therapy?

Key readings

- The way in which Rogers' six conditions are linked to basic anthropological and ethical issues is discussed in the four chapters by Schmid (2001/2002) in the series 'Rogers' therapeutic conditions' (series editor Gill Wyatt).
- Many articles in several languages dealing with the foundations of person-centred therapy can be found on the website www.pca-online.net.
- Practical consequences together with many examples of working at relational depth and ways of encountering the client are printed in Mearns & Cooper (2005).
- For practical case examples illustrating the different ways of resonance in the therapist, see, for example, Schmid & Mearns (2006) and Mearns & Thorne (2007).

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6

The actualizing person

ARTHUR C. BOHART

This chapter discusses:

- Carl Rogers' concept of the actualizing tendency and its relationship to the formative tendency and self-actualization
- The relationship of actualization to the concept of the fully functioning person
- The relationship of actualization to the idea of psychological dysfunction
- Implications for psychotherapy

The concept of the actualizing person is one of a number of related concepts that appear in person-centred writing. Carl Rogers referred to self-actualization, the actualizing tendency, the formative tendency and the fully functioning person (Bozarth & Brodley, 1991). He also wrote of 'becoming the self that one is'. In this chapter, I will review this cluster. I will also evaluate actualization and self-actualization by considering criticisms. This will include whether or not the concept of self-actualization is culturally biased. In addition, some theorists have emphasized the idea of the self as fundamentally relational (Barrett-Lennard, 2005; O'Hara, 1992; Schmid, 2003; Seeman, 2002), in contrast to the individualistic emphasis found in Carl Rogers' writings. I will also consider whether people are basically good. I will in addition take a look at relevant research. Finally, I will consider implications for psychotherapy and counselling.

Actualization and self-actualization

Precursors

The concept of self-actualization goes back to Kurt Goldstein (1963), who worked with individuals struggling to overcome brain damage. He believed the

person could not meaningfully be separated into mind and body. The whole person interacts with the environment. Goldstein studied people's adaptation to brain damage and believed that healing did not come through 'repair'. People do not return to states before the traumatic experience took place, but rather adapt to the new conditions caused by the traumatic state. Holistic organisms cope with threats to their integrity, whether physical or psychological, by developing adaptational skills. This seems similar to Carl Rogers' views on actualization. It is also similar to how clients 'self-heal' in psychotherapy (Bohart & Tallman, 1999).

Abraham Maslow (1968) saw actualization as a state that could be attained: a person could 'be actualized'. Self-actualization is at the highest level of a pyramid of needs. At the bottom of the pyramid are basic needs, such as for food and water. Safety needs are at the next level up, and belonging needs come next. Above these are needs for self-esteem. All these needs are 'deficit' needs, which means that if the person does not get enough food, water, safety, etc., they are motivated by the deficit to get more.

In this pyramid, each higher level defers to lower levels. Thus, if physiological needs are not satisfied, other higher needs such as belonging take second place. On top of the deficit needs is the need for self-actualization. This has to do with fulfilling one's 'potential'. The qualities of self-actualized individuals include being reality-centred and problem-centred, being comfortable being alone but also able to enjoy deep personal relationships, autonomy, positive non-conformity, a sense of humour, humility, a strong sense of ethics, creativity, an ability to have peak experiences and an acceptance of self and others. Self-actualized people also value truth, goodness, beauty, transcendence, perfection and justice. According to Maslow, one will only focus on self-actualization when the deficit needs lower in the hierarchy have been fulfilled. Thus, a poor farmer in a Third World country scraping out an existence would not be able to self-actualize. Maslow believed that certain individuals could be identified as self-actualized. He carried out biographical analyses and identified Eleanor Roosevelt, Abraham Lincoln and Albert Einstein as examples.

I have briefly mentioned these precursors to Rogers' ideas, particularly those views of Maslow, because Rogers' concept of self-actualization is different.

Carl Rogers' views

It is important to understand that, for Carl Rogers, self-actualization is a subset of the *actualizing tendency*, which is itself a subset of the *formative tendency*. Although, historically, the formative tendency was formulated later in Rogers' life, logically it is the core concept (see also Bozarth & Brodley, 1991).

The formative tendency

Rogers (1980; see also Ellingham, 2002) postulated that there was a tendency for things in the universe to move towards greater differentiation and integration. In opposition to the entropic principle, which says that the universe is gradually dissolv-

ing into random chaos, the formative tendency postulates the development of greater complexity and interrelatedness. Implied here is the concept of *emergence*, which is that, under the right conditions, the universe has a tendency to jump to higher and more complex levels of organization. Key to the concept of emergence is the idea of creativity – when things jump to higher levels of organization, new entities are created that are not merely the sum of the parts of the elements of which they are made. Kriz (2007) has provided a thorough-going treatment of the formative tendency in terms of systems concepts such as those of emergence.

The actualizing tendency

The actualizing tendency is the organismic embodiment of the formative tendency. Rogers (1959) postulated that living organisms are motivated by one overarching motive, which is to maintain and enhance themselves. This is a *biological* force. It includes a process of increasing differentiation as the organism grows, such as the differentiation of organs and of functions. It also includes the enhancement of effectiveness. Furthermore, it includes a movement towards autonomy and away from external control. Finally, it is a movement towards wholeness and integration (Wilkins, 2003). The actualizing tendency, however, is not merely a motive to survive. It is an *organizational* tendency to develop greater effectiveness. By 'organizational tendency', I mean that it is a proactive tendency to organize the organism for optimal functioning given the circumstances.

What about other motives? In order for an organism to maintain itself, it must seek out what is needed for maintenance, such as food, water, shelter, safety and so on. Thus, all other motives are implied by the actualizing tendency (Bozarth & Brodley, 1991).

It follows that the actualizing tendency is *generative*. It leads to growth and development, although the degree of generativity will vary from species to species. However, Rogers notes that it can be found even in plants. One of Rogers' (1980) examples of the actualizing tendency is of potatoes growing toward the light in cellars. The actualizing tendency would certainly be reflected in the learning capacity of organisms, which has been demonstrated even in lower organisms.

It is important to note that, for Rogers, the existence of this tendency is biological. It is not fundamentally moral. Nor does it necessarily go in a morally positive direction. At the human level, one could learn and become better and better at being a sadistic monster. All the view postulates is a tendency to proactively grow and adapt. Two basic texts from Rogers discuss more about his understanding of the actualizing tendency: 'The actualizing tendency in relation to "motives" and to consciousness' (Rogers, 1963), and Chapter 11 in *On Personal Power* (Rogers, 1977).

Self-actualization

Self-actualization is a subset of the actualizing tendency (see Chapter 5). It refers to maintaining and enhancing that portion of the phenomenal field which is the 'self'.

What is the self? The self is not an internal agent, nor a particular psychic mechanism that 'drives' the organism. Rather, the self is a conceptual *map* that the organism develops in order to help it cope (Shlien & Levant, 1984; Wilkins, 2003; see also Chapter 8). When they are fully functioning, people hold aspects of the self-concept tentatively (Rogers, 1961a, 1961b). It is not healthy to have too firm a self-concept, as selves are growing and changing, and one must be able to modify one's self-concept to incorporate new experience just as one must revise other concepts to fit with experience.

The concept of self-actualization is one of the most misunderstood of Rogers' ideas. Rogers has been accused of representing the values of an individualistic society, with the result that self-actualization is narcissistic – glorifying the actualization of individuals at the expense of others. These criticisms are not valid in terms of *Rogers'* concept of self-actualization, and I will consider these and related criticisms next.

Is the concept of self-actualization a Western, culturally specific notion?

It has been argued that Rogers' concept of self-actualization is culturally biased, reflecting a Western cultural emphasis on the separate, autonomous, individualistic self (the 'egocentric' self). In the critics' view of Rogers (Wilkins, 2003), self-actualization is presumably about actualizing the *self*, meaning that the individual focuses on personal development rather than on what is good for others. In contrast, many cultures in the world hold a 'sociocentric' view of the self: the self exists in terms of its relationships to others, including even one's ancestors.

However, to perceive Rogers' concept of self as culture-specific is to misunderstand it. His concept is compatible with cultures that view the self in relational rather than individualistic terms, and even with cultures that have no concept of self. First, it is not inevitable that a portion of the perceptual field will be differentiated out as 'self' if the culture does not have a concept of 'self'. Second, how the concept of self is differentiated out will crucially depend on how the culture defines that portion of the perceptual field. There is no reason why Rogers' view of the self, as a conceptual map, could not include a map of the self as connected and sociocentric.

Having defined the self, *self*-actualization means enhancing or actualizing the self as the self is defined for that person and culture. In a sociocentric culture, self-actualization would be very different from that in an individualistic culture, and might be family- or group-oriented. Having said that, it is true that, in many places, Rogers promoted an individualistic concept of self that does reflect his cultural biases (see Chapters 7 and 8). I shall say more about this when I consider specific characteristics of the fully functioning person.

Is self-actualization always positive?

Another criticism levelled at Rogers' view of self-actualization is that Rogers is presumed to believe that self-actualization will always go in a positive, prosocial direction, when

in fact actualizing the self might lead to narcissistic or self-centred behaviour. However, this criticism, too, is not justified. Self-actualization is not postulated to inevitably move in a positive, prosocial direction. What is implied is that the organism will work to maintain and enhance what is defined as the self. This could lead to the enhancement of a negative and destructive development of the self. Along these lines, Wilkins (2003) has noted that self-actualization (and, I should note, actualization itself) is not a goal of therapy. Rather, it is the actualizing tendency that makes possible the growth that happens in therapy, but actualization per se is not a goal.

It is true that Maslow's concept of self-actualization (see above) is positive. For Maslow, there are 'actualized people', who are creative, loving and prosocial. Rogers' concept of self-actualization (and actualization in general) has relatively little in common with that of Maslow. As we have seen, for Rogers self-actualization is the process of maintaining and enhancing the development of the self, and that may or may not be positive. Rogers believed that the *tendency* of actualization was to go in a positive, prosocial, constructive direction. However, he also recognized that environmental factors could inhibit it or distort it so that it did not (Bozarth & Brodley, 1991). Rogers would never have considered identifying individuals as 'self-actualized'.

Related concepts

Above, I have considered the three concepts of Rogers that use the term 'actualization'. In other places, he talks about 'being the self that one is' and 'the fully functioning person'.

To be the self that one is

In contrast to many theorists, Rogers never had a concept of the 'real self' as a separate and distinct entity that lay 'underneath' the overt self. To 'be the self that one is' does not mean being something other than what one's normal 'operating personality' is. Rather, it means being congruent, being in the process of continually integrating together all aspects of oneself. This is also what 'authenticity' means in client-centred theory. To be the self that one is also means to be an organism that is in a constant process of growing and learning. One is always one's real self at some level (Bohart, 2001) – but one's real self may be more restricted than it could be if one were open to the process of learning and change.

To be the self that one is, then, is to be in process, to be in touch with all aspects of oneself, and to have a trusting relationship towards oneself. These are all aspects of the 'fully functioning person'.

The fully functioning person

The concept of the 'fully functioning person' appears on the surface to be similar to Abraham Maslow's attempt to identify individuals who are self-actualized. For Maslow, self-actualization is a *state* of being that one can attain. In contrast, Rogers'

concept of the fully functioning person is a process concept. There is no such thing as an 'actualized' person since actualization is a process. The fully functioning person is someone who is open to information and is in the process of using that information to optimize growth. This is, essentially, someone who is open to learning (Bohart, 2003). A fully functioning person might be a person living in extreme dire circumstances and poverty, who does not meet Maslow's 'actualization' needs but who is doing the best for his or her family. Essentially, it is someone who is not acting in incongruent ways that impede optimal growing and learning.

Understanding the fully functioning person may be easier if we consider Rogers' Process Scale (see Rogers, 1961b), which is used in psychotherapy research. Rogers says that the scale:

> commences at one end with a rigid, static, undifferentiated, unfeeling, impersonal type of psychologic functioning. It evolves through various stages to, at the other end, a level of functioning marked by changingness, fluidity, richly differentiated reactions, by immediate experiencing of personal feelings, which are felt as deeply owned and accepted. (Rogers, 1961b, p. 33)

Rogers notes that this does not mean that the person is fulfilled, content or even happy (Rogers, 1961a). Rogers says that, 'life, at its best, is a flowing, changing process in which nothing is fixed' (1961a, p. 27; see also Chapter 8).

Elsewhere, I have elaborated on what I believe it means to be fully functioning (Bohart, 2003). First, personality is a process. By this, I mean that persons are continually growing and changing. This does not mean that there is no continuity in personality; in fact, there may be considerable continuity. Just as Rogers and Freud held to the basic tenets of their theories throughout their lives, yet evolved and changed them as well, characteristics of personality exhibit both continuity and change. People are 'structures-in-process'. Personality structures continually evolve. Most of these changes are small, subtle modifications. I have used, as an analogy, viewing the coastlines of the continents from the standpoint of a space satellite. They look the same as they did 30 years ago. Yet from a closer perspective, they are continually changing. On the other hand, individuals sometimes experience major shifts in their personalities (Miller & C'de Baca, 2001). What is most important is to recognize that people are in the constant process of learning and modifying their ways of being.

Second, persons live moment-by-moment. It has commonly been held that our behaviour in any given situation is determined by our past – by our beliefs and schemas, which are imposed upon situations. However, both Neisser (1967), a cognitive scientist, and Epstein (1991), a radical behaviourist, have pointed out that we never really do the same thing twice; we are always varying what we do. We blend what we have learned in the past with the specifics of the present situation. Behaviour is never an exact copy of the past. As I have written:

> general frames, personality traits, or rules that people use to help themselves cope in a given situation are *never* specific enough to concretely determine what the

> individual actually does. Behavior in any given situation is a creative application of the general structure to the specific circumstances in that particular situation, always resulting in something slightly new and different than before. (Bohart, 2003, p. 110)

Given these two aspects of human functioning, it follows that what most characterizes the fully functioning person is their potential for learning from experience. Included in this is a capacity for personal creativity: individuals will be creative in everyday life because each situation is a little different from the past, and presents the challenge to incorporate old learning into what is different and new about this particular situation.

Referring to this creative tendency, Rogers has described it as the capacity 'to discover a new sense of meaning in the influences which he undergoes and in his early experiences, and to change consciously his behaviour in the light of this new meaning' (Rogers, 1946).

Implied in the idea of learning is openness to information. This involves openness to both internal information and information from the external world. This suggests the importance of *congruent self–self relationships* as well as open, respectful dialogue with others.

Congruent self-self relationships consist of an open internal process of communication. One is able to listen to all aspects of oneself, including feelings, experiences and thoughts, in a 'friendly' way, if needed for creative problem-solving. This includes listening to any internalized 'voices' from parents and society. Such listening allows one to mine the potential wisdom in all points of view, and for the 'internal community' to move toward creative synthesis. All internal voices may have something to contribute (Bohart, 2003).

Congruence does not mean there will always be inner harmony. An inner sense of harmony comes and goes. Rather, congruence, defined as an open receptivity to all inner voices, means that the creative synthesizing process of the individual can move forward.

Of particular importance to being congruent is being open to *experiencing*. Both intellectual, rational thinking and feelings and 'experiencing' are important sources of information about how to deal with the world (see Chapter 7). Experiencing, as defined by Gendlin, is the bodily felt, direct, non-verbal sensing of patterns and relationships in the world, between self and world, and within the self. It includes emotion, but there is more to experiencing than emotion. Gendlin (1964) has called this a *bodily felt sense*. People sense and perceive relationships that they cannot easily describe in words.

This bodily felt sensing is potentially a valuable source of information. When Rogers (1961a) talked about the 'organismic valuing process', what he was referring to was the person's bodily ability to sense how interactions were going, and to intrinsically know what was personally important. Experiencing can be more complex than verbal-conceptual thought, although verbal-conceptual thought can be contained within it. It is the source of creativity (Bohart & Associates, 1996).

Thus, 'being in touch with our experiencing process' is a way of enriching functioning. When Rogers talked about 'trusting our organisms', that is what he meant. He did not mean that these felt senses were necessarily always accurate. Rather, fully functioning persons are open to *both* sources of information: bodily felt senses and intellectual-conceptual thought. It is the person's creative capacity to learn through listening to both sources of information that enhances functioning. Cutting off either one or the other because one distrusts either one's thinking or one's experiencing robs the person of their capacity to productively learn and grow.

I should particularly comment here on the idea that full functioning includes 'trusting one's feelings'. For Gendlin, feelings are bodily felt senses. They are not necessarily emotions like anger or fear or sadness. They are more like 'feeling that something is wrong in our relationship' or 'feeling like I don't know where I'm going'. Trusting feelings does *not* mean believing that a feeling such as 'there is something wrong with the relationship' is true. Rather, it means listening to it as a source of information. For instance, after exploration, it could turn out that there is nothing 'wrong' with one's relationship. Rather, one's partner has just been out of sorts for personal reasons and that has generated that feeling. However, if one does not 'trust' the feeling enough to explore it, one may never clarify what is going on.

Agency and autonomy

Carl Rogers' list of characteristics of the fully functioning person emphasizes the idea of the person as self-directed, independent and autonomous. For instance, Rogers (1961a, 1961b) lists an internal locus of evaluation, moving away from meeting expectations and away from pleasing others, and moving towards self-direction (see Chapter 5). However, this emphasis on autonomy and self-direction may be culture-specific.

Rather than focus on autonomy, I have suggested that we should place more emphasis on human *agency* (Bohart, 2003). No matter what culture they live in, persons have to be agentic in order to survive. That means they must take action and show initiative, although cultures may vary in terms of when to show initiative and when to accept one's fate. If individuals feel paralysed and helpless, they will not be able to explore, learn and cope in productive ways (Dweck & Leggett, 1988; Tallman, 1996). A sense of ableness or effectance may be more important than a sense of autonomy. The important thing is not necessarily personally chosen values versus societal values, but rather the degree to which the individual 'owns' and identifies with the values, and operates meaningfully from them (Sheldon & Houser-Marko, 2001). Individuals in sociocentric cultures may operate quite effectively from societally chosen values if they have internalized them.

Respect for others

Although Rogers stressed autonomy, it is clear from his views on psychotherapy that he highly valued an open, respectful stance towards others. He saw actualiza-

tion as including a movement towards constructive social behaviour (Bozarth & Brodley, 1991). Part of this comes from Rogers' (1980) belief in *multiple personal realities*; that is, there are many different ways to construe reality. As O'Hara (1992) has put it, individuals live in different 'perceptual universes'. Individuals and cultures find many different viable but workable ways of constructing personal realities. A key part of full functioning is the capacity to listen to and respect others' realities, as well as to productively dialogue with them. Another part is to prize and care for other people.

Peter F. Schmid's analysis of the authentic person

Schmid's (2003) philosophical analysis has led him to argue that the nature of the person is twofold (see Chapter 5 on encounter foundations). On the one hand is the person as an individual. When focusing on the person from this perspective, congruence between the experiencing organism and the self-concept becomes crucial for understanding effective functioning. However, Rogers also emphasized the nature of the person as fundamentally social. Humans are not only *in* relationships, they *are* relationships.

Thus, Schmid argues for a synthesis of the individualistic view of the self (internal congruence between experiencing and self-concept) and the view of the self as social. Schmid notes that self-determination *and* interrelatedness refer essentially to one and the same human nature, although we may view and experience these as different dimensions. Authenticity is the process of balancing individuality and interrelatedness. This includes becoming the author of one's own life, but also doing this in a context of responsible social relatedness.

Dysfunctionality

It may help, to understand the concept of the fully functioning individual, to briefly describe dysfunctionality. From a client-centred point of view, dysfunctionality occurs when individuals are not congruent: when they are unable to listen productively to themselves, and others, and to explore the situations they are in, so that they can adaptively learn and cope. This is most likely to happen when they hold their self-concepts rigidly and/or are frightened and defensive. They may then rely on old constructs and fail to examine the world afresh. Or if they have never learned to listen to themselves, they cannot engage in the creative synthesis process that gives them the best chance to forge new relationships.

Dysfunctional behaviour therefore arises from a failure to be open to information, and this particularly involves a failure to attend inwardly. This can occur because the person has rigid constructs that say certain information should not be attended to. Or it can be because the individual is negatively judgemental towards the self. A lack of self-acceptance or self-trust could be said to be a core cause. Self-acceptance meaning moving to a higher level of meta-cognitive functioning in which one is able to accept both the conflicting feelings and action tendencies, the beliefs and constructs

involved, and the negative self-judgements, listen to all of them receptively and find the wisest synthesis. This involves 'dis-identifying' with particular elements of consciousness and listening respectfully to all of them.

The biggest obstacle to the optimal operation of the actualizing process is defensiveness. Defensiveness gets in the way of the organism adopting an open, information-processing stance. Reducing defensiveness should lead to more effective prosocial behaviour. Writers such as Seeman (2002), Barrett-Lennard (2005) and Schmid (2003; see also Chapter 5) have argued that the nature of the person is fundamentally social. As such, reduction of defensiveness and openness to information should free individuals to move towards valuing greater integration and congruence with both others and the outside world. If, as many have proposed, 'evil' behaviour arises from a lack of empathy and egocentrism – an inability to de-centre and consider alternative points of view – then promoting openness may lead to 'integrative empathy' with others. I do not have space to elaborate on this notion further here, but this is one way in which becoming more open might conceivably lead to more prosocial behaviour.

Relationship of actualization to the fully functioning person

Putting the concept of the fully functioning person together with the process of actualization, we can say that the actualizing *process* is the organismic process or tendency to productively cope and grow in relationship to life's stressors. It is what allows development and adaptation. Fully functioning persons are persons who are operating in such a way (listening to feelings and so on) that allows the actualizing process to operate most effectively.

I want to comment here on the phrase 'actualizing one's potential'. In Rogerian theory, actualizing one's potential does not mean that one becomes wildly successful, incredibly creative, especially attractive to the opposite (or same) sex, rich, completely sure of oneself or whatever. To the extent that the phrase 'to actualize one's potential' has merit, the phrase refers to using one's capacities for learning and problem-solving in an optimal way. It means using one's potential *in the moment* to solve problems and grow. Thus, one may continue to be conflicted, unsure of oneself or depressed and still be actualizing one's potential if one is coping with these things and with life in a productive, learning-oriented way.

Are humans basically good?

Does Rogerian theory hold that human beings are basically good? The theory does not in fact postulate this. I have noted that self-actualization, and actualization in general, does not necessarily go in a prosocial direction. Shlien and Levant (1984, p. 3) have noted that 'we are basically both good and bad … What is fundamentally assumed [by Rogerian theory] is the *potential to change*.'

On the other hand, many of Rogers' writings imply a positive view of human nature. For instance, Rogers (Kirschenbaum & Henderson, 1990) describes individuals as having the potential to be positive, forward-moving, constructive, realistic and

trustworthy. Rogers saw this as an empirical observation. However, he does not say they *are* basically good but rather that they have this *potential*. Rogers (1961a, p. 27) has also said:

> I am quite aware that out of defensiveness and inner fear individuals can and do behave in ways which are incredibly cruel, horribly destructive, immature, regressive, anti-social, hurtful. Yet one of the most refreshing and invigorating parts of my experience is to work with such individuals and to discover the strongly positive directional tendencies which exist in them, as in all of us, at the deepest levels.

For Rogers, the key is how people are treated. If they were responded to in fundamentally positive, respectful and empathic ways (as in psychotherapy), Rogers observed that individuals grew in a positive, prosocial direction. What is different about this view compared with others is the implication that people can naturally and spontaneously grow in positive and prosocial directions given the proper supportive climate. They do not have to be 'taught' or 'programmed' to do so.

Research evidence

I will briefly look at evidence on the following propositions: Does personality grow and change over the lifespan or is it fixed? Is openness to experience associated with effective functioning? Is there evidence supporting the idea of an organismic valuing process? Is it of value to be autonomous and agentic? And do people actualize when confronted by psychological problems and/or trauma? (For a review of other evidence on actualization, see Joseph & Patterson, 2008.)

There continues to be controversy over the fixity of personality. McCrae and Costa (2003) have argued that personality grows and develops into early adulthood, but is relatively fixed from there on. Feshbach, Weiner and Bohart (1996) and McAdams (1994) have argued that whether personality changes or not depends in part on what one means by personality. If one means only personality traits, personality may appear to be relatively fixed from early adulthood on. However, if one views personality as the overall *organization* of traits, values and beliefs, personality does change. As the person grows and matures, the organization of self and personality gets reordered, not unlike how a kaleidoscope changes. However, even personality traits are not as fixed as some think. Srivastava, John, Gosling and Potter (2003) found changes in traits through late adulthood.

Rogers hypothesized that openness to experience would be associated with more effective functioning. Evidence is mostly supportive of this but not completely so. On the one hand, McCrae and Costa (1997) have argued, based on their research on personality, that those high on the trait of openness are not necessarily more functional than those towards the 'closed' end of the spectrum. Gendlin and his colleagues (Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968) found that openness to feelings (called by them 'focusing ability') was not associated with better adaptation, although it was associated with a capacity to profit from psychotherapy.

On the other hand, Seeman (2002) cites research reporting that openness does relate to higher levels of functioning. Kashdan and Silvia (2009) review evidence showing that curiosity, which they see as an interest in novelty and challenge, also correlates with higher levels of functioning. Kashdan and Rottenberg (2010) summarize evidence suggesting that psychological flexibility is generally correlated with psychological health.

Thus, the evidence suggests that openness is beneficial, but not in all cases. Openness is perhaps most useful when people have to *change*, such as in psychotherapy, or when they are confronted with major life challenges. Perhaps people who are not particularly open can live perfectly adequate and adjusted lives as long as they are adapted to their ecological niches and never face disrupting challenges. If so, the process scale may be more a description of the ideal processing mode for when individuals need to change than a description of ideal functioning for all persons in all situations. Further research is needed.

With regard to Rogers' hypothesis of an organismic valuing process, Sheldon (2004; Sheldon & Kasser, 2001), who was influenced by Rogers, has carried out a number of studies on what he calls 'self-concordant' goals – goals that are intrinsically important to the person and represent their intrinsic values. These studies have shown that those who pursue self-concordant goals are more likely to sustain their effort to achieve the goals, that these goals are associated with greater life satisfaction, and that as people age they are more likely to move towards following self-concordant goals (for further details, see Chapter 6 in Sheldon, 2004; Sheldon & Kasser, 2001).

With regard to Rogers' hypothesis that autonomy is beneficial, Joseph and Patterson (2008) have summarized a number of supporting studies. For instance, autonomous individuals exhibit greater personality integration (Koestner, Bernieri, & Holt, 1992) and less defensive functioning (Knee & Zuckerman, 1998). With regard to agency, which I have suggested may be the more broadly important ingredient of autonomy, Bandura's (1997) work on self-efficacy has shown that individuals who feel able to agentically enact effective behaviour cope better with life in many different ways.

Concerning the hypothesis that humans exhibit a capacity for actualization, Bohart and Tallman (1999) have argued that there is considerable evidence showing that individuals do indeed have a capacity to 'self-right' when confronted with problems and with adversity. Studies have shown that many individuals actually grow from trauma rather than being devastated by it (Tedeschi, Park, & Calhoun, 1998), that humans are generally resilient, that many people overcome problems without the aid of professionals, and that self-help activities often work as well or almost as well as professionally provided psychotherapy. Bohart and Tallman (1999, 2010) have further argued that the whole pattern of evidence concerning humans' capacities for self-righting and for getting better when in psychotherapy support the hypothesis that it is the client's capacity for self-healing and self-righting that makes therapy work, and that it is primarily the client who is the 'therapist' (Box 6.1).

Box 6.1

How clients self-heal in psychotherapy

Research supports Carl Rogers' hypothesis that it is clients who self-heal in psychotherapy when given proper supportive conditions (Bohart & Tallman, 2010). The percentage of change that can be attributed to clients is anywhere from 40 to 87 per cent, while the percentage attributed to therapy techniques ranges from 1 to 15 per cent.

Client involvement is the most important factor. Clients interpret therapy environments in their own ways. As one therapist said after participating in a research study in which she and her clients both kept records of their experience of therapy: 'I learned that there is no relationship between my perceptions of what is going on in therapy and my clients' perceptions.' Yet clients' perceptions of what happens relate more to whether therapy works than do the perceptions of therapists. The things they find helpful are often the things therapists have not even noticed, and the things therapists had not intended to be helpful.

Clients invent new interventions. They creatively and usefully misinterpret interventions offered by therapists. For instance, clients interpret therapists' empathy responses as insight-giving if they are looking for insight, and as support-providing if they want support. They productively manage their therapists. They work with bad therapist responses to turn them into gold. They creatively carry therapy outside the office to blend it with what is going on in their everyday life in order to facilitate change. Overall, clients are the 'forces' that make therapy work.

Of course, individuals are not completely or perfectly self-healing and self-righting, otherwise there would be no suicides, no deaths due to drugs and no need for psychotherapy. However, Bohart and Tallman would generally agree with Masten, Best and Garmazy (1990, p. 438) that human development is 'highly buffered and self righting'. It is that capacity that therapists help clients to mobilize.

Implications for psychotherapy and counselling

The major implication of the idea of actualization is that, given the right conditions, individuals will spontaneously move towards solving problems, towards better relationships and towards more adaptive self-organization. These conditions are ones that support openness to information and reduction of fear and defensiveness. These conditions consist of empathic listening, demonstrations of unconditional positive regard and therapeutic congruence. Therapy does not need to guide someone towards positive, proactive choices. Rather, it can support their own actualizing process in such a way that it moves in a positive direction (Box 6.2). As Carl Rogers (1974, p. 8) has

said, therapy 'relies much more heavily on the individual drive toward growth, health, and adjustment'. It 'is a matter of freeing (the client) for normal growth and development' (p. 8). And 'the confidence of the client-centred therapist is in the *process* by which truth is discovered, achieved, and approximated. It is not a confidence in truth already known or formulated' (p. 9).

Box 6.2

Implications for psychotherapy

The basic implication of the actualizing tendency for psychotherapy is that as long as the therapist is there, present and listening, the client has a good chance of finding his or her way forwards. In addition, therapists need to trust their client's self-actualizing process. The example of Mr Jones, who came to therapy struggling with relationship issues, illustrates this.

> My experience was that all the client did was complain, session after session. I saw no process happening in terms of what I had learned should be happening, from any theoretical point of view, for therapy to work. I did not see the client deeply experiencing. I did not see him actively accessing emotion. I did not see him challenging his dysfunctional cognitions. I did not see him forging new understandings of the relationship of his present to his past. I did not see him becoming more open to experience. I did not seem him moving toward holding his constructs more tentatively. While he complained a lot, I did not see him exploring his experience, like I was used to seeing in Rogerian therapy. In fact, the complaints seemed the same from session to session and I felt thoroughly ineffective with this client. Yet after a while the client moved to make some definite and more functional choices about the relationship he had been struggling with. He terminated therapy, told me how helpful I had been and moved on with his life. Over time I have periodically heard from him. He is doing well, and he tells me how helpful I was! (Bohart, 2008, pp. 176–7)

This view sees therapy more as self-healing, self-righting and actualization than as 'repair'. Growth occurs primarily (although perhaps not exclusively) through the positive development of new and expanded capacities. As Peter Schmid (2004, p. 40) has said, 'The challenge is not so much what has gone wrong, but where the possibilities are to facilitate the process of life, i.e., the self-healing capacities'.

In conclusion, actualization is not the *goal* of psychotherapy. Rather, it is the 'engine' that makes psychotherapy work. As clients are able to think and experience in an open, supportive relationship, they are able to use their growth capacities to move forwards in finding solutions to their problems.

Conclusion

Carl Rogers' concept of the actualizing tendency is based on his broader idea of the formative tendency. The formative tendency is a tendency for things in the universe to move towards greater levels of integration. The actualizing tendency is the tendency of the organism to develop in ways which maintain and enhance itself. Self-actualization has to do with a tendency of humans to actualize based upon their views of themselves. Self-actualization goes in a positive direction if the person is open to experience, but can go in negative directions if the person is defensive.

Actualization is a process and not a state. There is no such thing as an actualized person in Carl Rogers' theory, in contrast to the ideas of Abraham Maslow. Rogers does have a concept of the fully functioning person. Fully functioning persons are those who are open to experience; they are not necessarily perfectly adapted human beings. Actualization is not a goal of therapy but rather the force that makes therapy work.

Points for reflection

- In what ways have you noticed yourself growing in life?
- Have you been aware of instances of your clients' resiliency and creativity?
- Do you think humans are basically good, and if so, why do they do evil things?

Key readings

■ Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

This book, also available through the American Psychological Association's online service, examines how clients actively make therapy work, with implications for practice from a person-centred-based integrative perspective (see Chapter 17).

■ Bozarth, J. D., & Brodley, B. T. (1991). Actualisation: A functional concept in client-centered therapy. In A. Jones & R. Crandall (Eds.), *Handbook of self-actualization* (Special issue of *Journal of Social Behavior and Personality*, 6(5), 45–60).

This article presents an incisive analysis of the actualizing concept.

■ Kriz, J. (2007). Actualizing tendency: The link between person-centered and experiential psychotherapy and interdisciplinary systems theory. *Person-Centered and Experiential Psychotherapies*, 6(1), 30–44.

This article presents Kriz's attempt to explain the actualizing tendency in terms of ideas from modern science.

■ Wilkins, P. (2003). *Person-centered therapy in focus*. Thousand Oaks, CA: Sage.

Wilkins incisively presents and evaluates criticisms of the notion of actualizing tendency, as well as of other person-centred views.

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7 Experiential and phenomenological foundations

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This chapter discusses:

- Rogers' emphasis on *experiencing* as the essence of human being
- The *phenomenological* foundations of this experiential perspective
- The nature of experiencing
- The difficulties with, and limitations of, basing a therapeutic approach on experiential foundations
- Strategies for translating an experiential perspective into therapeutic practice

The primacy of experiencing

What are you experiencing as you read this? Perhaps there is a feeling of interest at what you are about to read, or perhaps you are thinking, 'I'll give this chapter a go and see if it's worth carrying on with.' Maybe, as you are reading this, you are aware of sounds around you, and perhaps there are other distractions: a child pulling on your sleeve or a partner wondering when you are going to turn the light off. Almost certainly, your experiencing will have a bodily dimension to it: a slight aching in your arms, perhaps, or tiredness behind the eyes, or the feel of the outside air on your skin. Try the exercise in Box 7.1 to develop an awareness of your immediate experiencing and to help clarify the focus for the present chapter.

Box 7.1

Developing an awareness of your experiencing

Working on your own or with a partner (who should just take a listening role), take 5 minutes or so (each) to describe what you are experiencing *right-here-and-now*. Try to stay entirely focused on your experiencing, perhaps by starting each description with the phrase 'Right now I am experiencing …' For instance:

- 'Right now, I am experiencing … a tingling in my feet.'
- 'Right now, I am experiencing … the blue sky outside my window.'

If you feel uncomfortable or awkward at any point, try just describing that, for instance:

- 'Right now, I am experiencing … feelings of embarrassment.'

When you have finished the exercise, reflect on, or discuss with a partner, how easy or difficult it was to stay focused on your experiencing.

Within many psychological and psychotherapeutic fields, such experiencing might be considered relatively superficial: *epiphenomena* that overlay the more fundamental psychological laws and processes. From a person-centred standpoint, however, our subjective experiencing is far more than that: not just an important part of who we are, but the very essence of our existence. Rogers (1951, pp. 494–5) writes:

> If we could empathically experience all the sensory and visceral sensations of the individual, could experience his whole phenomenal field including both the conscious elements and also those elements not brought to the conscious level, we should have the perfect basis for understanding the meaningfulness of his behavior and for predicting his future behavior.

Such was Rogers' belief in the 'fundamental predominance of the subjective' (1959, p. 191) that the first two of his 19 classic propositions, in which he developed a theory of personality and behaviour, emphasize the experiential nature of human beings. In his first proposition, he states that 'Every individual exists in a continually changing world of experience of which he is the center' (1951, p. 483); and in his second proposition, he adds: 'The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality"' (1951, p. 484).

Rogers' (1959) first two propositions were a direct challenge to the dominant psychological ideology of his day, *behaviourism*, which held that only externally observable behaviours and stimuli were the subject matter of a 'proper' science. For in contrast to this 'empty organism' school of thought (Rogers, 1959), Rogers states that our experiencing of the world is an undeniable part of who we are: that to be human is to experience the world in ever-changing ways. More controversially, from

a behavioural perspective, Rogers argues in his second proposition that human behaviour cannot be understood without reference to this experiencing. In other words, he suggests that there is no direct link between external *stimuli* and human *responses*; rather, our responses to the world are wholly mediated by the way in which we perceive and experience it, *because this is what we take reality to be* (Box 7.2).

Box 7.2

Responding to the world as perceived

The proposition that human beings react to their world *as they perceive it* is evident throughout the work of counselling and psychotherapy. Manjit, for instance, a client of Mick's, was a young woman who experienced profound anxiety in social situations and who turned down virtually every social invitation, choosing instead to remain isolated in her small one-bedroom flat.

When this was explored in therapy, Manjit described how, in social situations, she felt others were scrutinizing and judging her, watching her every move and always ready to pounce with some criticism. Her perception of social situations in this way was particularly evident, a few weeks into therapy, when she attended a party at work and was devastated when a colleague said to her that he thought she was 'cool'. For her, this was clear evidence that other people did not like her – that they perceived her as distant, aloof and unfriendly – and she expressed her determination never to attend social events at work again.

Whether or not Manjit's colleague had actually intended this comment to be insulting, her emotional and behavioural reaction was a direct result of her perception of it. And, indeed, that Manjit's responses were a direct result of how she perceived her social 'field' was also evident in the therapeutic relationship. One session, for instance, Manjit turned up about 10 minutes late and spent the next 20 minutes or so finding it almost impossible to engage with therapy. When Mick finally picked up on this and asked her what was going on, she said that she really just wanted to leave: she felt *so* embarrassed about being late and was sure that Mick saw her as a 'stupid, irresponsible little girl'. In fact, Mick's reaction to Manjit's lateness had been entirely different – he had been anxious that she might not turn up and was mainly relieved to see her – but this had no direct bearing on Manjit's response to the situation; rather, her response was entirely determined by Mick's 'reaction' *as she perceived it*.

This second part of the second proposition – that the perceptual field is, for the individual, 'reality' – also challenges behaviourist thinking because it questions the idea of a fixed, universal 'truth'. While Rogers (1951), in his 19 propositions, does

not claim that an individual's 'reality' is the '"true" reality', his assertion that our perceptions are 'our reality' fundamentally challenges the idea in which human behaviour and experiences are determined by some external, trans-personal 'truth'. For Rogers, 'There are as many "real worlds" as there are people!' (1980, p. 102), each of us inhabiting our own personal and subjective sphere through which we act towards others.

This rejection of ultimate, universal laws (or at least the suggestion that they are irrelevant because we can never know them) means that, for Rogers (1959), 'truth' is not something that can be found outside an individual. Rather, for Rogers, truth lies within us. He writes:

> *Experience is, for me, the highest authority*. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming in me.
>
> Neither the bible nor the prophets – neither Freud nor research – neither the revelations of God nor man – can take precedence over my own direct experience. (Rogers, 1961, p. 24)

The emergence of an experiential perspective

How did Rogers come to develop such an emphasis on the experiential, subjective dimension of human existence? Tracing his work back to 1942, one finds in *Counseling and Psychotherapy* no mention of 'experience', 'experiencing' or the 'subjective' realms of human existence. What one does find, however, is an assertion that clients are the 'best guides' to the issues that are of most importance to them, and a rejection of therapeutic techniques that attempt to direct, guide or reassure clients from a position of external authority. What one also finds in this book is the presentation of reflective therapeutic techniques that show 'unmistakable signs of intention to comprehend the inner world of the client' (Shlien, 1970, p. 102). To a great extent, then, Rogers' assertion of the 'fundamental predominance of the subjective' would seem to be rooted in his belief that the primacy locus of change is in individuals themselves, rather than in those around them, and that the role of the therapist is to help clients to develop a deeper insight into their own feelings and attitudes.

By the time *Client-centered Therapy* was published in 1951, however, Rogers' approach had taken on a much more experiential tone. To a great extent, this was probably due to his engagement with the work of Donald Snygg and Arthur Combs, two leading exponents of *phenomenology* (see below) in the field of psychology (see Rogers, 1959, p. 197). Snygg and Combs' 1949 book *Individual Behaviour: A New Frame of Reference for Psychology*, the manuscript of which was read and commented on by Rogers, contains many of the key ideas that Rogers would subsequently publish as part of his 19 propositions.

Phenomenology

Syngg and Combs (1949), throughout *Individual Behaviour*, describe their approach as a 'phenomenological' one, and the book itself is based on a 1941 paper by Snygg entitled 'The need for a phenomenological system of psychology'. Rogers, too, describes his theory of personality and behaviour as 'basically phenomenological in character' (1951, p. 532; see also 1964, p. 129), and his approach to theory as well as practice has been described as 'phenomenological' by numerous authors both within (see, for example, Embleton Tudor, Keemar, Tudor, Valentine, & Worrall, 2002; Lietaer, 2002; Schmid, 2004; Shlien, 1970; Thorne, 1992) and outside (for example, Glassman, 2000; Pervin & John, 1997; Spiegelberg, 1972; Spinelli, 2005) the person-centred approach.

A brief description of the phenomenological movement will make it readily apparent why Rogers' theory and practice has been so frequently characterized in this way. Developed by the German philosopher Edmund Husserl around the turn of the twentieth century, phenomenology argued that the starting point for all knowledge must be our lived-experiences: 'the "inner evidence" that is given to us intuitively in our conscious experiencing of things' (Cooper, 2003b, p. 10). In other words, to truly understand ourselves – as well as the world around us – we must turn our attention to our conscious lived-experiences, and Husserl outlined a range of strategies by which this can be achieved (Ihde, 1986; Spinelli, 2005). These can be summarized as follows:

- Put to one side (*bracket*) prejudices, biases, expectations and assumptions, and focus on experiences as actually experienced.
- Explore experiences *descriptively* rather than trying to explain or analyse them.
- Treat all experiences as being of equal significance (*horizontalization*).

In many respects, then, person-centred therapy can be seen as a form of 'applied phenomenology'. Not only is it orientated around an 'intensive and continuing focus on the phenomenological world of the client' (Rogers, 1980, p. 2153), but the practices of bracketing assumptions, remaining at a descriptive level and treating all experiences as being of equal worth can also all be considered to be integral elements of person-centred therapy (Worsley, 2001).

At the same time, however, it would be wrong to assume that Rogers was strongly influenced by Husserl and the post-Husserlian phenomenologists. There are no records of Rogers studying any of these authors' writings (Spiegelberg, 1972), and even Donald Snygg, from whom much of Rogers' phenomenology seems to have been derived, 'had no direct knowledge of their works and was certainly not influenced by them in formulating his phenomenological program' (Spiegelberg, 1972, p. 147). Moreover, there are some significant contrasts between a traditionally phenomenological perspective and a person-centred one (Spiegelberg, 1972; Spinelli, 2005): in particular, phenomenologists would not hold with the a priori notion of an actualizing tendency but would strive to bracket this along with all other assumptions.

The nature of experience

Up to this point, we have explored how Rogers, like the phenomenologists, emphasized the experiential nature of human being. What we have yet to explore, however, is what Rogers and other person-centred theorists actually meant by 'experience'.

Used as a noun, Rogers defines it in his classic 1959 chapter in Koch's book on the science of psychology as follows: 'all that is going on within the envelope of the organism at any given moment which is potentially available to awareness' (p. 197). He goes on to state:

> It includes events of which the individual is unaware, as well as all the phenomena which are in consciousness. Thus it includes the psychological aspects of hunger, even though the individual may be so fascinated by his work or play that he is completely unaware of the hunger; it includes the impact of sights and sounds and smells on the organism, even though these are not in the focus of attention. It includes the influence of memory and past experience, as these are active in the moment, in restricting or broadening the meaning given to various stimuli. It also includes all that is present in immediate awareness or consciousness. It does not include such events as neuron discharges or changes in blood sugar, because these are not directly available to awareness. It is thus a psychological, not a physiological definition.

Here, and in other person-centred writings on experiencing, we can see a number of key aspects of this phenomenon.

Potentially available to awareness

Our experiences are all that, at any given moment, are *potentially* available to awareness. This use of the term 'potentially' is of critical significance, for Rogers (1951), drawing on the work of Angyal (1941) as well as Snygg and Combs (1949), is not suggesting that experience is only that which we are aware of. Rather, what we are aware, or conscious, of is just one part of our experiential field – that part which comes to be symbolized – and there may be many other parts of our experiential field that do not come to be symbolized in our consciousness. Rogers gives the example above of experiencing hunger but being so caught up in work or play that the individual is not actually conscious of feeling as such. This distinction between what is experienced and what is symbolized in awareness is critical to the person-centred theory of personality and development (see Chapter 8) because it leads to the possibility that certain experiences can be *subceived*, that is, discriminated without awareness because they do not fit in with a person's concept of self (Rogers, 1959).

Rogers' (1959) emphasis on phenomena that are *potentially* available to awareness means that his model of psychological functioning is quite different from a Freudian, psychodynamic one, with its tendency to emphasize psychological processes that are *inaccessible* to consciousness. Shlien (1970) makes the distinction here between a model of psychological functioning in which people *will not* express or acknowledge certain things, and one in which they *cannot* do so. For Rogers, 'a large

proportion of this world of experience is *available* to consciousness' (1951, p. 483), and this belief, that people *can* become aware of the most significant determinants of their lives if they are provided with an environment in which they feel safe enough to do so, is at the heart of a non-directive, non-interpretative approach to therapy.

In the moment

Second, for Rogers, experience is something that exists in the moment: at the 'instant of action' (Snygg & Combs, 1949, p. 15). Our experience is what is immediately present to us. Past or future events can be part of our experience, but only in as much as they are manifested in the here-and-now, for instance as memories or as deliberations on future choices.

Private

Third, experience is private. It has an 'inward' (Gendlin, 1970b, p. 138) or 'inner' (Lietaer, 2002, p. 8) quality. John Shlien writes, 'Experience is subjective, that is, it takes place within the opaque organism of the experiencer, and *may* not be public or even repeatable' (1970, p. 99).

Bodily

Fourth, experience has a bodily dimension to it. It is sensory, visceral and affective, a 'psycho-physiological' flow (Rogers, 1980, p. 141). Experience is what we receive 'within' us through all our sensory modalities (Rogers, 1951): what we feel, smell, hear, see and taste in the immediate moment that is potentially available to awareness. This bodily dimension of experiencing was particularly emphasized by Eugene Gendlin (Box 7.3), one of Carl Rogers' key progeny, and someone who had a significant influence on Rogers' own understanding of experience and experiencing (Rogers, 1980; Spiegelberg, 1972).

Box 7.3

Gendlin's experiential perspective

Eugene Gendlin worked closely with Carl Rogers in the 1960s before going off in his own direction to create focusing-oriented psychotherapy (Gendlin, 1996). Gendlin was a philosophy student when he first started working with Rogers and is now a prominent philosopher as well as a theorist and researcher on psychotherapy.

Gendlin's theory of experiencing is about how we know ourselves and the world. He held that humans are interactive creatures who know the self and the world in a holistic, bodily-based way. Experiencing is the *fundamental* way we know. It includes thinking and emotion but is broader than either. Gendlin focuses

on *felt meanings*. These are meanings experienced in the body, not just thought. Felt meanings are not the kind of feelings that we call emotions. They are felt or experienced senses of how we are with ourselves and the world – what is important for us, where we are located in our lives in the moment. They include things like 'feeling helpless', 'feeling rejected', 'feeling loved', the feeling of knowing, the feeling of understanding, the feeling of being understood, having a feeling that we are on the right track, and so on. When we talk about knowing something 'in our gut', we are talking about bodily-based felt meanings. Most of us have had the experience of knowing something before we could put it into words. You are a bodily creature: your whole body is picking up information and you are knowing things before you can say them.

From this perspective, what is needed for therapeutic change is a *felt shift* at the bodily level, that sense of getting it at the 'gut level'. Talking *at* oneself or thinking *about* oneself rarely helps. Gendlin says you have to tune into and listen to that nagging feeling, almost as if you were an empathic therapist, letting words and images come from the feeling. This is the process Gendlin calls *focusing*. Therapists have in one way or the other to help clients tune into that felt sense and put it into words or symbols in order for the person to *carry forwards* their experiencing of the problem in new and more productive directions.

Unlike Rogers and Snygg, Gendlin *had* immersed himself in the works of Husserl and the phenomenological school, and he was particularly influenced by the writings of Maurice Merleau-Ponty (Gendlin, 1962; Purton, 2004), a French existential-phenomenological philosopher who had emphasized the embodied nature of human being (Cooper, 2003b). For Gendlin (1962), experiencing had a powerful pre-logical, *felt* dimension to it – what he termed the *felt sense* – and he argued that this dimension preceded, and would always exceed, the concepts that were used to symbolize it.

Process-like

Fifth, Rogers (1951), like Snygg and Combs (1949), emphasized the fluid and non-static nature of experience. It is an ever-changing gestalt, and if people are understood primarily in terms of their subjective experiencing, the very nature of human being is to be a 'living, breathing, feeling, fluctuating process' (Rogers, 1961, p. 114) rather than an object-like 'self'.

Gendlin, again, with his roots in phenomenological and existential philosophy (a school of thought that emerged in the mid-nineteenth century and focused on the question of what it means to exist; see Cooper, 2003a, 2003b, 2004), put particular emphasis on this aspect of experience. He describes experiencing as a *flow* of sentient living, an *event* (Gendlin, 1970a) and writes, 'It is a process, an activity, a functioning, not a bag of static

things' (Gendlin, 1962, p. 30). Indeed, in contrast to Rogers' earlier writings, Gendlin focuses on experienc*ing* as a process rather than *experience* as a noun, and Rogers' himself adopts this reorientation in some of his later thinking (Rogers, 1980; Spiegelberg, 1972).

Further aspects of experiencing

Within the person-centred and experiential fields, several other authors have highlighted further aspects of experience and experiencing. Bohart (1993), for instance, emphasizes the way in which experience is always holistic – our experiential field is an irreducible whole – and is always located within a particular context. Greenberg and van Balen (1998), along related lines, emphasize the way that our experiences tend to be organized into coherent forms, such that experiencing has a purposive, meaning-creating quality. Cooper (2003a, 2003b, 2004), drawing on existential philosophy, has suggested that experiencing is characterized by both a sense of freedom and a sense of limitations, as well as having a basic orientation towards the future.

Finally, several authors, in both the person-centred and experiential (see, for example, Wolfe & Sigl, 1998) and existential-phenomenological (for example, Sartre, 1958; Spinelli, 2005) fields, have differentiated between *immediate*, *primary* or *pre-reflective* experiences, and those which are *reflective* or *secondary* – that is, between our direct experiencing of the world (for instance, 'feeling cold') and our conscious awareness of that experiencing ('I'm noticing that I'm feeling cold'). Such a distinction is important when considering how some experiences may come to be symbolized and incorporated into the self-concept (see Chapter 8) whereas others may be experienced but never fully acknowledged or 'owned' (Box 7.4).

Box 7.4

What is *not* experienced?

In articulating what constitutes human experiencing, it may also be useful to reflect on what would *not*, in itself, be an experience. This might include:

- 'Unconscious processes': by definition, these are not potentially available to awareness.
- External events: for instance, what 'really' happened in a client's life.
- 'Truths': for instance, whether someone is a good or bad person.
- Behaviours: what someone 'actually' did.
- Other people's experiences: by definition, these are not experienced by the person themselves.

From an experiential perspective, therapists would generally try to steer away from an exploration of such non-experiential phenomena, for instance trying to ascertain whether or not a client's partner 'really is' a selfish person. However, the client's *feeling* that their partner is selfish would be an entirely appropriate subject matter for an experiential practice.

Limitations

What are the challenges, or limitations, to an experiential understanding of human being and change?

Perhaps the key question here is whether such an approach, by focusing on just that which is perceived or experienced, overlooks many of the key determinants of human behaviour. From a psychodynamic perspective, for instance, human behaviour is driven by libidinal and aggressive drives that lie far below the threshold of experiencing (Wolitzky, 2003). It is not just that we *choose not* to become aware of such 'unconscious' forces, it is that we *cannot*, just as we cannot become aware of such biological processes as how our muscles generate lactic acid. From such a perspective, then, the person-centred orientation around experiencing not only disregards many key determinants of behaviour, but also fails to explain why people experience their world in the way that they do.

A second critique of a classical person-centred perspective on experiencing comes from a very different angle. For Rogers (1951, 1959), as we have seen, experience is something 'subjective', 'private' and 'within' the individual. In recent years, however, many philosophers, psychotherapists and psychologists, both within the person-centred field (see, for example, Barrett-Lennard, 2005; Mearns & Cooper, 2005; Schmid, 2004) and outside it (for example, Crossley, 1996; Merleau-Ponty, 1962; Spinelli, 2005), have argued that experience is not located 'inside' people but lies rather on an *intersubjective* (that is, between people) plane (see Chapter 8). While we might assume, for instance, that our thoughts take place wholly inside our heads, the fact that we think with language – which is derived from a sociocultural context – means that our very experience of thinking is infused with the ideas and communications of others. This does not discount the importance of experiencing, but it does suggest that we need to be wary of conceptualizing it in wholly internal, private or subjective terms. It also suggests that we may need to find new ways of thinking about experiencing that locate it in a more interpersonal context, as some person-centred writers are now beginning to do (Cooper, 2005; Mearns & Cooper, 2005; Schmid, 2003; see also Chapters 5 and 8).

It is also important to note that not all person-centred therapists would consider experience and experiencing as being so central to the person-centred approach. Indeed, as with many other issues in the field, there is a wide spectrum of opinion on how 'experiential' the person-centred approach to therapy is, or should be (see Chapter 4). Whereas Lietaer, for instance, writes that 'the focus on the experiencing process constitutes … the deepest core of our paradigm' (2002, p. 8), others, like Sanders (2004), consider it neither a primary nor a secondary principle of person-centred therapy. There are also those who, like Prouty, warn of the dangers of 'phenomenological reductionism', whereby 'The process of experiencing rather than the existential *whole being* of the self is related to by the therapist' (1999, p. 9). In this respect, it could be argued that a focus on experiencing, and a tendency to steer clients away from non-experiential content (see Box 7.4), introduces a degree of directivity that is inconsistent with a non-directive standpoint. And, indeed, this

tension between an experiential and a non-directive emphasis could be seen as the basic fault-line dividing the person-centred world.

Implications for practice

Understanding clients, first and foremost, as *experiencing* subjectivities is a key element of most person-centred practice, and the more that therapists can come to understand their clients in this way, the more they are likely to be able to enter into their clients' lived-worlds. Indeed, as Empleton-Tudor et al. (2002, p. 18) write, empathy is essentially just 'a process of attending phenomenologically to the phenomenological world of another'. Deepening an understanding of an experiential-phenomenological perspective can also help therapists to develop their unconditional positive regard for clients, by understanding that unconditional positive regard is not about condoning or colluding with a client's behaviour, but about accepting that everything they experience is exactly that: what they experience, and neither good nor bad. An experiential perspective can also help therapists to clarify what it means to be congruent, that it is about being aware of – and, where appropriate, disclosing – one's own self-experiences.

In this respect, experiential-phenomenological constructs and practices can provide a useful 'way in' to developing competences as a person-centred practitioner, one that can act as a valuable adjunct to a more traditional approach, based around listening skills and the 'core conditions' (Rogers, 1957) (Box 7.5).

Box 7.5

Developing person-centred practice from an experiential-phenomenological perspective

The following exercises are means of developing skills and competences in person-centred practice within a training or group context, and are derived from phenomenological and experiential concepts rather than being directly based on Rogers' (1957) core conditions. Although these exercises are designed for students in the initial stages of training, the practices being described are relevant to person-centred therapists at all levels of activity.

Exercise 1: Developing an experiential focus

- Form a triad and decide who will be 'therapist', 'client' and 'observer'.
- For 5 minutes or so, the client should talk about some issue or concern of meaning to them.
- The therapist should then summarize the *experiential* aspect of the client's narrative: that is, what he or she experienced, either in the past or while talking about their concern. (For instance, 'You felt really upset when your partner told you that he just wanted to be in his own space on holiday, and when you described that you wondered if you were turning into your mother.')

- The observer should then feed back on how much they felt that the therapist really stayed with the experiential component of the client's narrative, as opposed to straying into other areas, like external events or others' experiences (see Box 7.4).
- Swap roles until everyone has had a turn in each role.
- As a follow-up exercise, the client can be invited to talk for a longer period of time (maybe 10–15 minutes), with the therapist now reflecting back the client's experiences as and when they feel it is appropriate (rather than just at the end of the time period).

Exercise 2: Working descriptively

- Form a triad and decide who will be therapist, client and observer.
- For 10 minutes or so, the client should talk about some issue or concern of meaning to them.
- During this period, the therapist should try and help the client 'paint a picture' of their experiences: that is, to lay out as fully as possible what they have experienced, or are experiencing. The therapist can say, or do, anything that they think will facilitate this descriptive exploration. However, some suggestions are:
  - Listen, and encourage the client to 'paint their own picture'.
  - Explore the 'what?' of the experience, rather than the 'why?' (description, not analysis).
  - Try not to judge any aspect of the experience as more valid than any other (horizontalization).
  - Useful questions/response might be:
    - 'Can you tell me more about that experience?'
    - 'What was that like?'
    - 'What did you experience then?'
    - 'What were you thinking/feeling/wanting at that time?
    - 'I sense you experienced x …'.
- The observer should then feed back on how much they felt that the therapist helped the client to paint a picture of their lived experiences, and the client and therapist should debrief.
- Swap roles until everyone has had a turn in each role.

Exercise 3: Bracketing

- Form a triad and decide who will be therapist, client and observer.
- For 10 minutes or so, the client should talk about some issue or concern of meaning to them.
- The therapist should encourage and reflect the client's *experiencing*, as above.

- At the end, the therapist should take 5 minutes to explore things that got in the way of them being able to focus solely on experience, for instance:
  - a desire to interpret;
  - assumptions about what might be going on;
  - anxiety about not being helpful enough.
- The observer and client should then feed back on other areas, if any, in which they felt the therapist's own agenda influenced their work.
- Swap roles until everyone has had a turn in each role.

Deepening an understanding of human beings as experiencing organisms would also seem central to developing a person-centred conception of wellbeing, where 'full functioning' is described in terms of an increasing openness to experience, a willingness to be a 'process' rather than a 'product', and an ability to live fully in each moment (Rogers, 1959, 1961). As Empleton-Tudor et al. put it, from a Rogerian standpoint, the person who emerges from a long-enough experience of effective therapy can essentially be described as 'living phenomenologically' (2002, p. 19).

Furthermore, the capacity to distinguish what we are experiencing from some external 'reality', and to realize that others may experience things in very different ways, may also be a key component of good psychological health. In the case of Manjit described earlier in this chapter, for instance, she came to see that, however strongly she might feel others were judging her, there was also the possibility that they were not. And by coming to see her perception of the situation as exactly that – a perception and not a truth – she began to feel less socially anxious, and more willing to relate and engage with others.

Conclusion

Person-centred theory and practice is firmly grounded in an experiential-phenomenological perspective, and an understanding of the principles and assumptions underlying this worldview provides person-centred practitioners with a valuable opportunity to deepen their engagement with their work. Through engaging with clients as experiencing subjectivities, and through examining the nature of this experiencing, person-centred trainees and therapists can come to extend their levels of empathy, unconditional positive regard and congruence, thus helping their clients to become more fully open to their own lived-being.

Points for reflection

■ 'Experiencing is the essence of human being.' To what extent do you agree or disagree with this statement, and why?

■ What would you consider to be the key aspects of experiencing? Do these match the ones outlined in this chapter?

■ To what extent do you agree with the proposition that people *can* become aware of the most significant determinants of their lives?

Key readings

■ Spinelli, E. (2005). *The interpreted world: An introduction to phenomenological psychology* (2nd ed.). London: Sage.

An excellent introduction to phenomenology and its implications for therapeutic practice.

■ Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. London: Prentice-Hall.

A highly recommend introduction to phenomenology.

■ Moran, D. (2000). *Introduction to phenomenology*. London: Routledge.

An in-depth review of phenomenological philosophy and concepts.

■ Snygg, D., & Combs, A. W. (1949). *Individual behavior: A new frame of reference for psychology*. New York: Harper & Brothers.

Essential reading for those interested in the roots of Rogers' experiential-phenomenological perspective. Although this has been out of print for many years, it is available through interlibrary loans or second-hand booksellers such as bookfinder.com.

■ Gendlin, E. T. (1962). *Experiencing and the creation of meaning: A philosophical and psychological approach to the subjective*. Evanston, IL: Northwestern University.

Gendlin's most important philosophical text: complex, but essential reading for those interested in the underlying philosophical ideas behind his work.

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8

Developmental and personality theory

MICK COOPER

This chapter discusses:

- The historical development of theories of personality and growth in the person-centred field
- Rogers's classic model of human development
- Evidence in support of the classical model
- Contemporary critiques and developments of Rogers' classical model
- The relevance of developmental and personality theory to person-centred practice

How do human beings come to be the people they are? More specifically, why do some people come to experience the psychological difficulties that they do? These are the questions that developmental and personality theorists in the counselling and psychotherapy field have asked, and this chapter looks at person-centred attempts to answer these questions. The principal focus of this chapter is on developments from childhood to adulthood. For developments into older adulthood, see Chapter 20.

Historical development

According to Barrett-Lennard (1998), Rogers' interest in personality-related issues, such as the self-concept, *can* be traced back to the beginnings of his career in 1931 and his development of a 'personality adjustment' measure. It was not until 1947, however, that he discussed these issues more publicly and systematically, presenting

'Some observations on the organization of personality' in his address as retiring president of the American Psychological Association.

This was followed in 1951 by his publication of 'A theory of personality and behaviour' in *Client-centered therapy*, a series of 19 propositions that together constituted a systematic conceptual framework for understanding human personality and development. This framework was extended and refined in Rogers' (1959) 'A theory of therapy, personality, and interpersonal relationships, as developed in the client-centred framework', published in Koch's *Psychology: A Study of Science*. This chapter is less well-known than Rogers' 1951 propositions, but it is generally regarded – by both Rogers and others – as his most definitive, rigorous and systematic statement of theory (see, for example, Barrett-Lennard, 1998).

In 1963, Rogers published some further thoughts on the *actualizing tendency*, but after that date he made no further significant contributions to developmental and personality theory (Mearns, 2002). Indeed, from the 1960s to around the early 1990s, person-centred thinking in the field of human development and personality almost entirely stagnated. However, in the last decade or two, there has been a significant re-emergence of interest in this area (see, for example, Biermann-Ratjen, 1998b; Cooper, 2000; Mearns, 2002; Warner, 2005), as well as compelling new research support from such humanistically orientated fields as self-determination theory (Ryan & Deci, 2000) and the self-concordance model (Sheldon, 2001).

Rogers' classical model of human development

In developing a theory of personality and human development, Rogers (1951, 1959) drew from a wide variety of sources, including his own students (see, for example, Standal, 1954). Two areas of thinking, however, can be considered of particular importance to Rogers' work. The first of these is the field of phenomenology (Snygg & Combs, 1949), which starts from the assumption that human existence can be best understood in terms of how people *experience* their world (see Chapter 7). The second assumption, coming from the field of humanistic psychology (see, for example, Maslow, 1943), is that individuals are propelled forward in the direction of *growth* or *actualization* (see Chapter 6). Rogers defines this actualizing tendency as 'the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism' (1959, p. 196) and identifies it particularly in the *organismic valuing process*. This is described as the organism's innate tendency to positively value (as manifested in feelings of satisfaction) those experiences that are self-enhancing and self-maintaining, and to negatively value (as manifested in feelings of dissatisfaction) those experiences that are not self-enhancing or self-maintaining.

Rogers' model of human development, as outlined in his 1959 'Koch' chapter, is presented in Figure 8.1. This can be summarized as follows:

In the first stages of life, the child's experiencing of their world is an integrated, undifferentiated whole, in which there is no differentiation between 'me' and 'not-me' experiences. As the child develops, however, a portion of their experiential field

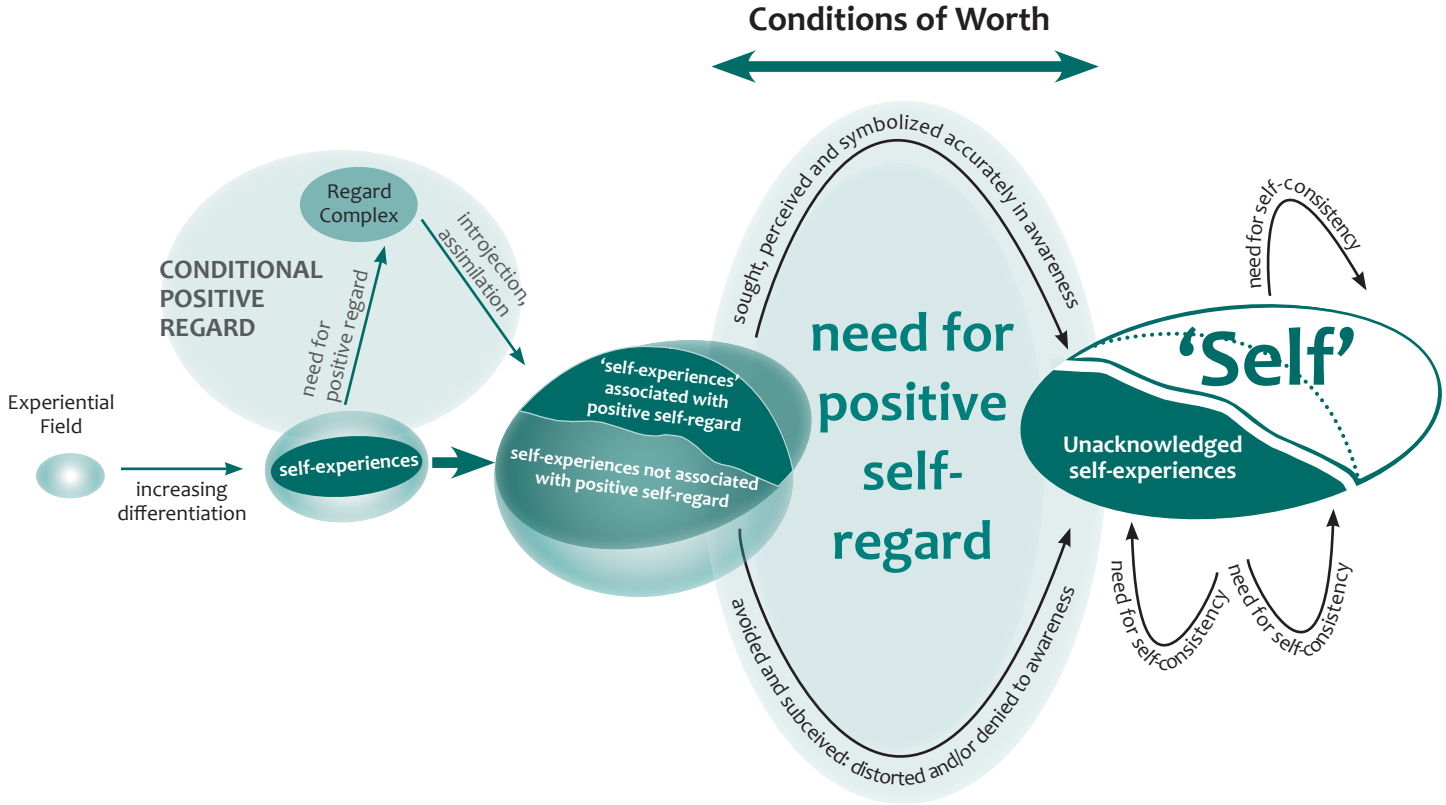

Figure 8.1 Rogers' (1951) classical developmental model

becomes differentiated off as 'self-experiences': those experiences which the individual associates with her own being, for example *I* am brushing my teeth.

Ideally, the child's self-concept exactly matches their actual experiencing. A young girl, for instance, gets bored feeding her baby sister bottles of milk, and thereby come to see herself as someone who sometimes gets bored caring for others. The 'spanner in the works', however, is the infant's emerging need for *positive regard*: the desire to 'experience oneself as making a positive difference in the experiential field of another' (Rogers, 1959, p. 208). Because of this, the child increasingly turns her attention to the positive regard she evokes in others and begins to associate her self-experiences with certain levels of acceptance from others.

In some very rare cases, a child will experience positive regard in relation to all her self-experiences – what Rogers refers to as *unconditional positive regard*. More likely, however, the child's environment will provide *conditional positive regard*: in other words, she will begin to discover that certain of her self-experiences are associated with positive regard whereas others are not. She may experience, for instance, that people like her when she feels affectionate towards her younger sister but not when she feels resentful towards her. Hence, the child develops a *regard complex*: 'all those self-experiences, together with their interrelationships, which the individual discriminates as being related to the positive regard of a particular social other' (Rogers, 1959, p. 209).

As the child develops, the associations between self-experiences and positive regard then come to be *introjected* and *assimilated*, such that the child comes to experience *positive* self-*regard* independently of the positive regard transactions from external others. Hence, for instance, the child no longer needs others to 'reward' her for experiencing affection towards her sister; now she rewards herself, through the medium of the total *self-regard complex*. The child has come to associate positive self-regard with some of her experiences but not with others: she has acquired *conditions of worth* (Rogers, 1959). And because, as an internalization of the need for positive regard, the child has a need for positive *self*-regard, she comes to selectively seek out those self-experiences that are associated with positive self-regard and avoid those self-experiences which are not. So, for example, she spends more time feeding her baby sister than her organismic valuing process may otherwise indicate because it evokes in her good feelings about herself. In other words, she has *introjected* a set of values that may not actually be consistent with her own organismic valuing process (Rogers, 1951).

Concomitant with these behavioural changes, the child's need for positive self-regard also means that she may begin to *perceive* her self-experiences selectively. Self-experiences consistent with the child's conditions of worth will evoke feelings of positive self-regard. Hence, the child should feel quite comfortable with reflecting on these self-experiences, symbolizing them accurately at the level of conscious awareness and integrating them into her overall concept of self.

But those self-experiences inconsistent with the child's conditions of worth are likely to bring up more negative feelings, such that the child is less likely to feel comfortable with reflecting on them. Hence, she may be more likely to leave these self-experiences

at a *pre-reflective* level, refraining from symbolizing them accurately at the level of conscious awareness and failing to integrate them into her overall concept of self. Rogers' (1951, 1959) refers to this process of discrimination without reflective awareness as *subception* and suggests that it can be achieved by two strategies: *denial* and *distortion*. So for example, the young girl may simply deny that she feels bored feeding her baby sister, or she may distort the felt-sense of boredom by telling herself that she is tired or worn out. Hence, she can maintain her concept of herself as a 'good girl'.

As well as denying some of her actual experiences, the child may also introject experiences associated with positive self-regard that lie entirely outside the realms of her own self-experiencing. The consequence of this selective perception, then, is that a discrepancy

> develops between the self as perceived, and the actual experience of the organism. Thus the individual may perceive himself as having characteristics *a*, *b*, *c*, and experiencing feelings *x*, *y*, *z*. An accurate symbolization of his experience, however, indicate characteristics *c*, *d*, *e* and feelings *v*, *w*, *x*. (Rogers, 1959, p. 203)

This discrepancy is then reified as a consequence of the organism's need for self-consistency – a concept developed by Lecky (1945) – in which the organism further denies to awareness those experiences that are inconsistent with their sense of who they are, while further acknowledging and incorporating self-consistent self-experiences into their sense of self.

By the time children have reached adulthood, therefore, Rogers' (1959) model of human development suggests that most people are estranged from themselves to varying degrees, with levels of self-estrangement closely corresponding to levels of psychological disturbance. This association can be posited to exist for a number of reasons. First, if individuals are denying their experiences – or introjecting 'experiences' that are not their own – their inherent, organismic ability to evaluate whether an experience is self-enhancing or self-maintaining is likely to be overridden. Hence, estranged individuals are less likely to engage in organismically satisfying and self-enriching activities, and more likely to engage in the kind of self-stagnating or self-destructive activities that can lead to feelings of boredom, hopelessness and depression.

Second, the organism's attempt to maintain and enhance *all* of its capacities means that, even if certain experiences are distorted or denied, they will continue to be generated by the organism-as-a-whole in its attempts to actualize. Consequently, the individual is likely to experience frequent feelings of anxiety: a sense that some unacceptable self-experience is lurking on the edges of awareness, threatening to disrupt the consistency of the self and undermine feelings of positive self-regard. Furthermore, where subceived needs or feelings are so strong that they become expressed overtly, the person may experience a highly disconcerting sense of 'I am doing things which are not myself, which I cannot control' (Rogers, 1951, p. 514), perhaps even of being taken over by something 'alien'.

Finally, at an interpersonal level, if an individual is not able to acknowledge to themselves what it is that they really need, they may be much less able to communicate

this to others in clear, direct and transparent ways. Hence, others may find it much more difficult to provide them with the things the person actually needs (Box 8.1).

Box 8.1

Neville: beneath the mask of masculinity

Neville was an Anglo-Chinese man who came to therapy wanting to feel less isolated in his life. He was concerned that he 'frightened people away' by acting in a bullish, aggressive and intimidating manner, and was particularly keen to develop more 'balanced' relationships with other men. Neville's 'bullishness' was apparent from our first few sessions together: he would often end meetings by saying that the therapy felt like a waste of time, and I was aware of feeling increasingly apprehensive before each meeting. When I shared this with Neville, he replied that seeing my vulnerability made him feel 'nauseous', although he added that, in some ways, it might also help him to be more able to be vulnerable back.

Neville had mainly lived with his father, a 'self-made man', during his teenage years, and had learnt from him that men should be independent, self-sufficient and invulnerable. As our work together progressed, however, Neville began to acknowledge that his bullishness towards others was actually rooted in something very different: deep feelings of vulnerability and fear towards them – that they would betray, dominate or irreversibly hurt him. Indeed, at the beginning of our 45th session, Neville sat down and acknowledged that he was actually 'petrified' of other people, particularly men in authority. When I asked him whether that also extended to me, he said that it did, and that he felt high levels of anxiety each time he came to talk to me. 'I feel,' said Neville, 'that I present a mask of how I am feeling, but underneath it I am extremely scared and frightened.'

In person-centred terms, Neville had come to subceive and distort his feelings of vulnerability towards others as this was inconsistent with his concept of himself as independent and invulnerable. However, these subceived feelings actually conveyed something very important about his organismic needs: for tenderness, gentleness and care from others. Through denying them, it then became very difficult for him to ask for – or invoke – these responses from others, explaining, perhaps, some of his frustration and bitterness towards the world. Moreover, because he knew that, at some level, he really did experience fear towards others, he experienced shame and self-disgust.

Through person-centred therapy, Neville was able to come to acknowledge and accept his feelings of vulnerability; he could begin to show more of this side to others, and ask for more of what he wanted. Very slowly, his relationships with others became less hostile, he 'softened' and he could begin to experience more of the intimacy and affection in his life that he so wanted.

Research evidence

Rogers' (1951, 1959) classical model may provide a compelling account of the emergence of psychological disturbances, and case studies such as Neville's (Box 8.1) illustrate this process, but is there any wider and more rigorous evidence to demonstrate its validity? Unfortunately, as Patterson and Joseph (2007, p. 118) point out, 'person-centred theory has not provided a concentrated focus for research during the past 30 years'. Nevertheless, in the closely related fields of personality and social psychology, specifically self-determination theory and the self-concordance model, researchers have taken some notable steps towards validating key elements of Rogers' model (Sheldon & Kasser, 2001; see also Box 8.2 and Chapter 1).

Box 8.2

Self-determination theory and the self-concordance model

Self-determination theory was developed by American psychologists Richard Ryan and Edward Deci in the 1970s (Ryan & Deci, 2000) and is one of the few well-established, contemporary psychological theories that is highly consistent with person-centred principles. It is a framework for understanding human motivation that puts particular emphasis on the value of *intrinsic motivation* –'the inherent tendency to seek out novelty and challenges, to extend and exercise one's capacities, to explore, and to learn' (Ryan & Deci, 2000, p. 70) – as contrasted with *extrinsic motivation*, the performance of an activity to obtain some external reward or approval.

The *self-concordance model*, developed by Kennon Sheldon and colleagues (Sheldon & Elliot, 1999), extends this distinction to hypothesize that *self-concordant*, *intrinsic* goals (that is, those which are consistent with an individual's authentic needs and values) will lead to greater satisfaction on attainment and be associated with greater motivation than extrinsic, externally derived goals.

For a further discussion of these two perspectives and their relevance to humanistic theory and practice, see Patterson and Joseph (2007) and Sheldon and Kasser (2001).

Consistent with the self-concordant model (Box 8.2), Sheldon and colleagues have shown that the attainment of goals that can be considered consistent with a person's intrinsic, organismic needs (for instance, self-acceptance and closeness to others) leads to an increase in wellbeing, while the attainment of more extrinsic goals (for example, financial success and public admiration) 'does little to aid individuals' (Kasser & Ryan, 2001, p. 126; see also Sheldon & Elliot, 1999; Sheldon & Kasser,

1998). Indeed, in a classic series of studies, Kasser and Ryan (1993, 1996) showed that individuals who were more orientated to extrinsic goals experienced higher levels of psychological and physical distress than individuals orientated to intrinsic goals, and also had weaker feelings of empathy to others (Sheldon & Kasser, 2001). Consistent with this finding, research using the *authenticity scale* (Wood, Linley, Maltby, Baliousis, & Joseph, 2008) has also shown that individuals who feel out of touch with themselves, are strongly influenced by others and tend not to live in accordance with their own beliefs and values experience lower levels of happiness, and more anxiety and stress.

Research from the self-concordance field has also found that, over time, people tend to move towards intrinsic goals and away from goals that are more orientated around external demands (Sheldon, Arndt, & Houser-Marko, 2003). This is both over the lifespan, and across periods as short as 20 minutes. For Sheldon and colleagues, such findings provide evidence for the existence of Rogers' (1951, 1959) organismic valuing process: that human beings have an innate tendency to move towards more genuinely satisfying and fulfilling goals – those which are more concordant with their deepest values and needs.

Critiques and developments of the original model

Within the wider psychological and psychotherapeutic field, a range of criticisms have been levelled at Rogers' (1951, 1959) model of human personality and development, in particular that it is overly optimistic and that it ignores 'unconscious' forces (see Wilkins, 2003, for an excellent review and rebuttal). This chapter, however, will focus more specifically on criticisms of Rogers' classical model that have emerged from *within* the person-centred field, and on contemporary attempts at reformulation.

Intersubjective and relational perspectives

From within the person-centred field (see, for example Barrett-Lennard, 2005; Bohart, 2003; Holdstock, 1993; Mearns & Cooper, 2005; O'Hara, 1992; Schmid, 1998; Stinckens, Lietaer, & Leijssen, 2002; Tudor, 2010; Tudor & Worrall, 2006), one of the most common criticism of Rogers' (1951, 1959) classical theory of personality and human development is that it is overly *individualistic* (see also Chapters 5–7 and 15). As we have seen, Rogers' developmental model begins with an organism that is essentially separate from its world – a self-contained, self-regulating, discrete entity – that has the potential to achieve an independent and autonomous existence. For many contemporary *intersubjective* theorists, however, this idea is highly problematic (see, for example, Barrett-Lennard, 2005; Mearns & Cooper, 2005). They challenge the assumption that 'human beings are little self-encapsulated "shells" or monads' (Bohart, 2003, p. 112) and argue, instead, that we are 'fundamentally and inextricably intertwined with others' (Mearns & Cooper, 2005, p. 5).

Development as relational

Drawing on recent developments in the field of relational psychodynamics (see, for example, Bowlby, 1979; Stern, 2003), several contemporary authors within the person-centred field (Biermann-Ratjen, 1998b; Mearns & Cooper, 2005; Schmid, 1998; Warner, 2001, 2002, 2005) have outlined a model of child development that puts an other human being at its very core. These approaches differ from Rogers' (1951, 1959) classical formulation in that, long before infants are considered capable of discriminating self-experiences, they are seen as being powerfully influenced by the existence of others. Moreover, in contrast to Rogers' classical model, relationships with others are not just seen in a negative sense – in terms of inhibiting the impact of conditional positive regard – but also in terms of their importance in facilitating positive growth and development.

With respect to what infants might need from early relationships and what might happen if these needs are not met, contemporary developmental theorists have suggested a range of possibilities. For Biermann-Ratjen (1998a, 1998b), infants require much the same conditions for healthy psychological development as clients do for constructive personality change in therapy: unconditional positive regard and empathy from a congruent other. Note here that Biermann-Ratjen is suggesting that infants have a 'need for positive regard from the first days of life onwards' (1998b, p. 120) – a position that is different from Rogers' (1951) assertion that the need for positive regard is a secondary or learnt need. Through being parented in this way, argues Biermann-Ratjen, infants can come to integrate all of their self-experiences into their sense of self and thereby develop as integrated, well-functioning adults.

Like Biermann-Ratjen (1998b), Warner (2000, 2001, 2002, 2005) also emphasizes infants' need for a benign caregiving environment. In her writings, however, she puts particular emphasis on young infants' need to be empathically understood, such that they can learn to effectively *process* – that is, make sense of – their life experiences (see Chapter 23). 'Infants are initially almost totally dependent on adults to hold experiences in any sort of sustained attention, to modulate the intensity of experience, and to name experience,' states Warner (2005, p. 93); and if the adult *scaffolds* this processing in an adequate way, Warner suggests that the infant can begin to take over this processing activity for themselves. When this does not happen, however, the infant may develop a *fragile* processing style in which they are not fully able to 'hold' their own experiences in attention. Consequently, they may easily feel violated, threatened and misunderstood by others, which may lead to feelings of defensiveness and rage towards others. Without being able to hold their own experiences in attention, Warner suggests that they may experience feelings of emptiness inside.

A third contemporary person-centred perspective on early relational needs and the problems that may emerge if these are not met is outlined by Mearns and Cooper (2005). While Biermann-Ratjen (1998b) and Warner (2005) – alongside Rogers (1951, 1959) and most attachment theorists (see, for example, Bowlby, 1979) – place an emphasis on what young infants need to *receive* from relationships, Mearns and

Cooper argue that infants also have a basic need to *give* and to be involved in a bi-directional encounter: 'They want to be loved, but they want to interact with that other and that love, to give as well as to receive, and to experience an immediate and engaged contact' (2005, p. 8). Based on this hypothesis, Mearns and Cooper (2005) suggest that difficulties in adulthood may be linked to a person's failure to experience in-depth relational encounters with others, such that they cannot relate to others in intimate and satisfying ways, and ways that can buffer them against crises in their life-world.

The person in context

Moving beyond a focus on dyadic relationships, other authors within the person-centred field (see, for example, Barrett-Lennard, 2005; Bohart, 2003; Cooper, 2003; Embleton Tudor, Keemar, Tudor, Valentine, & Worrall, 2002; Mearns, 2002; O'Hara, 1992) have emphasized the importance of understanding human beings within their life-world: seeing human beings as fundamentally woven into their social, cultural, political and historical contexts. Perhaps the most ambitious framework developed here is that of Barrett-Lennard (2005), who suggests nine different systems of relation within which human existence is embedded, each with the potential for multiple subsystems and complex, interdependent connections between them:

1. The individual
2. The person's primary two-person relationships (for example, husband or wife/partner)
3. The family system
4. Small groups (for example, a child's class)
5. Large groups/organizations (for example, a child's school)
6. Communities of association and belonging
7. States and nations
8. The human race
9. Planetary life systems.

In Barrett-Lennard's (2005) framework, in order to fully understand our clients we must understand them in terms of the multiple social systems in which they are embedded. To understand them solely at the individual, intrapersonal level will give us only ever a partial understanding.

Optimal development is not only towards autonomy

As well as being criticized for its individualistic understanding of human being, Rogers' (1951, 1959) theory of personality and development has also been criticized for its implicitly individualistic values (Bohart, 2003; Mearns & Cooper, 2005; Mearns & Thorne, 2000; O'Hara, 1992): for the fact that 'maturity' and psychological wellbeing involve a movement towards greater independence, self-regulation and autonomy. In other words, Rogers' model has been criticized for implicitly valuing independence over interdependence, and for promoting the values of a very particular, dominant

economic group – white, Western, liberal males (Bohart, 2003; Holdstock, 1993) – in a way that mistakenly assumes that these are universal human motives and needs.

In contrast to Rogers' (1951, 1959) original theory, then, several contemporary authors have argued that optimal psychological development is not simply a matter of moving towards autonomy. Rather, it also involves the capacity to develop a *relational self* (O'Hara, 1992) and to effectively mediate the psychological 'push–pull' (Embleton Tudor et al., 2002) between the desire for independence and the desire for relationship. Along these lines, Mearns (2002; Mearns & Thorne, 2000) suggests that the individual's *actualizing tendency* (that is, their desire to actualize their personal potential) will inevitably come up against the forces of *social mediation* (derived from the action of the actualizing tendency on the social life space), and that both of these forces have an intrinsic validity. In other words, for Mearns (2002), it is not just the case that the 'positive' drive of the actualizing tendency is 'cruelly' inhibited by the constrictions of society. Rather, social restraints have an important role to play too, and the *actualizing process*, as Mearns defines it, is the configuring and reconfiguring of this balance between the actualizing tendency and the forces of social relationships.

A substantial-relational being

Like that of Mearns (2002), the work of Schmid has also emphasized this individual–relational duality (see Chapter 5), arguing that a unique characteristic of the person-centred approach is that it understands people *both* as separate *and* in relation to others. In Chapter 5, he writes: 'Only in the dialectic of both interpretations, not in an "either-or", but in a "both-and" does the mystery of the person become accessible'.

Self-pluralistic perspectives

As with the intersubjective and relational theorists above, *self-plurality* theorists have also moved away from Rogers' (1951, 1959) tendency to conceptualize personality and human development at the level of the unitary individual. In this case, however, it is from entirely the opposite direction. Here, several contemporary person-centred authors (Barrett-Lennard, 2005; Cooper, 1999; Cooper, Mearns, Stiles, Warner, & Elliott, 2004; Keil, 1996; Mearns, 2002; Mearns & Thorne, 2000; Warner, 2000, 2005), as well as those in the related fields of experiential therapy (Elliott & Greenberg, 1997; Greenberg, Rice, & Elliott, 1993; Stinckens et al., 2002), have argued that a focus on the individual overlooks not only the multiplicity of which the individual is a part, but also the multiplicity *by which the individual is constituted*. In other words, what these authors have suggested is that human beings are made up of multiple elements – or *configurations of self* (Mearns, 2002; Mearns & Thorne, 2000), *modes of being* (Cooper, 1999), *inner persons* (Keil, 1996), *subselves* (Barrett-Lennard, 2005), *voices* (Stiles et al., 1990) or *parts* (Warner, 2000) – and that an understanding of human beings as such can play a valuable part in the theory and practice of person-centred therapy. Research in the field of *assimilation theory*, developed by

person-centred theorist Bill Stiles (Stiles & Glick, 2002; Stiles et al., 1990) has been of particular value here: demonstrating how multiple *voices* or *agencies* can be identified in clients' lives and narratives, and providing a method, framework and tools by which they can be empirically investigated.

As with other aspects of person-centred theorizing, much of this theory can be directly derived from phenomenological observation or from clients' own accounts of their experiencing (see Mearns, in Cooper et al., 2004). During session 34, for instance, Neville (see Box 8.1) spontaneously introduced into our work his sense that he was 'like Jekyll and Hyde', that there was a part of him that fought, sadistically, to establish power above others, and another, 'liberal' part of him that was aghast at this behaviour. Another client of mine, Sophia, described herself as 'schizophrenic': confident and extraverted in much of her life, but also prone to moments of social terror and paranoia.

In attempting to incorporate self-pluralism into a person-centred understanding of human development and personality, self-pluralistic theorists have suggested a number of revisions or additions to Rogers' (1951, 1959) classical model (although Rogers, 1959, himself was in no way adverse to the idea of self-plurality). Barrett-Lennard (2005), Cooper (1999) and Keil (1996), for instance, have all pointed to the fact that different social environments, or relationships, are likely to confer positive regard on to a person for very different behaviours and experiences. A young man may, for instance, experience a great deal of positive regard from his peer group for enjoying alcohol, while his parents may be horrified by this behaviour. Hence, extending Rogers' original theory, these authors have suggested that people may develop a multiplicity of self-concepts to accrue positive regard – and hence self-positive regard – in a multiplicity of different social contexts.

Cooper (1999) has proposed another modification of Rogers' (1951, 1959) original model that can allow for the development of multiple 'selves'. Cooper suggests that when people are faced with experiences that are dissonant with their self-concepts, denying or distorting the experiences may not be their only means of maintaining a consistency between self-concept and experience. Rather, he argues, what they may do is to develop a *new*, altered self-concept that is consistent with the current experience. For example, if a person who usually sees themselves as measured and calm starts to experience anger, they might temporarily develop a new concept of themselves as a 'rageful person' and subsequently subceive those experiences that do not fit this temporary self-concept.

Mearns (2002; Mearns & Thorne, 2000) proposes a further means for understanding how multiple selves may develop. He suggests that they may start off as introjections – for instance, 'I am a failure' – around which the person may then constellate various cognitive, affective and behavioural elements. This is a way in which the person can give the introjection more of an 'established and functional' status, but it is also a way of compartmentalizing the introjection off so that the person can concurrently hold different views of themselves. Mearns (like Warner, in Cooper et al., 2004) goes on to suggest, however, that under situations of extreme stress – such

as trauma or abuse – the various configurations of self may not be able to deal with the incongruities between them, leading to further separation and a state of dissociation.

In contrast to these developmental models, Barrett-Lennard (2005) proposes that the existence of multiple selves may also be a consequence of the inherently pluralistic nature of human beings. As he points out, we have a biological nature, a social nature, a psychological nature and a huge array of specialized subsystems within our body and mind. Hence, there is no reason to assume that the self should have a 'single constant or master pattern' (p. 6). Along similar lines, Warner (in Cooper et al., 2004) argues that one of the most basic tendencies of human beings is to *self* – to create coherent narratives about who they are – but that the corollary of any such *self-ing* is a tendency to identify experiences that do not completely fit into one's pre-existing sense of self.

As can be seen, a number of similarities exist in terms of how contemporary person-centred theorists conceptualize self-plurality, but there are also a number of significant differences. Cooper's (1999) model, for instance, comes from a phenomenological standpoint (see Chapter 7) and thereby conceptualizes self-plurality in terms of the multiple ways in which a person may *experience* their world. Other authors (see, for example, Keil, 1996) have, however, taken a more structural position, envisaging the different 'parts' as actual person-like entities inhabiting an 'inner world'. Closely related to this, while Cooper (1999) sees the person as moving from one mode of being to another over time (*diachronous plurality*), theorists such as Keil (1996) tend to see the different 'persons' as existing concurrently (*synchronous plurality*). Another debate within the self-pluralistic field is the issue of whether there is a 'deeper', 'truer' self or whether all the different 'parts' can be considered equally authentic (see Cooper et al., 2004).

Despite these differences, what all these self-pluralistic theorists agree on is that it is not the existence of different 'parts' per se that is associated with psychological distress. Rather, what is seen as being psychologically problematic is when these different 'parts' of the person relate to each other in conflictual, critical or abusive ways, as opposed to having harmonious, empathic and open relationships between them. This is consistent with the empirical findings. Assimilation research, for instance, has shown how the presence of dissociated or *unassimilated* voices is associated with the existence of psychological difficulties, whereas assimilated or integrated voices have the potential to act as a resource (Stiles, 2002). Stiles gives the example of a client, Debbie, whose sudden, uncontrollable angry outbursts were transformed into a capacity for appropriate assertiveness. He writes: 'in successful therapy, a problematic, unwanted voice established contact with the community, negotiates an understanding, and is assimilated into the community' (Stiles, 2002, p. 358).

As a final point, it is important to note that, although self-pluralistic thinking has led to some interesting developments in the person-centred field, it also tends to run counter to one of the most basic principles of the approach: the fundamentally holistic and integrated nature of human being (Tudor, 2010). From this standpoint, therefore, it is important that self-pluralism is not taken too literally, particularly that it is not imposed on clients, however subtly. Indeed, for Tudor (2010, p. 63), the present challenge for person-centred practitioners and theorists is in very much the

opposite direction from self-pluralism, aiming to 'to embody a holistic attitude and to develop a language or "languaging" of wholes.'

Implications for practice

Person-centred theories of personality and development have always tended to follow on from, rather than precede, person-centred theories of therapeutic practice. Rogers' (1942) first major publication on the practice of therapy with adults, for instance, *Counseling and Psychotherapy*, appeared almost 10 years before his 1951 propositions and contained virtually no mention of developmental or personality processes. Although in such therapeutic fields as the psychodynamic approach, then, theories of human development and theories of therapeutic practice have tended to grow up side by side, the same could not be said within the person-centred approach.

Furthermore, given the person-centred emphasis on the unique of each individual client (Cooper & McLeod, 2011) and the importance of bracketing a priori assumptions (see Chapter 7), it could be argued that predefined developmental theories can only serve to undermine person-centred work (see, for instance, A. Rogers, 2001). However, as Rogers (1964, p. 133) himself acknowledges, it is simply not possible to engage with clients in an a-theoretical way: we will always have certain assumptions about how our clients are and have developed. The issue, then, is not whether or not we engage with our clients through a theoretical lens, but whether or not we are aware of the implicit theories that we will inevitably hold, and whether or not we are able to put them to one side. In this respect, the role of developmental and personality theories for person-centred therapists may be less about telling us how our clients developed, and more about providing us with a body of theory and research that can help can help us to reflect on, and challenge, our pre-existing assumptions.

Moreover, with some clients such as Neville (see Box 8.1), the theory may provide us with a framework that can help us make better sense of their experiences. This might be in supervision, in private reflection, or in collaboration with the client themselves. Neville and I, for instance, explored the ways in which he might have come to associate invulnerability with being a 'proper' man, and Neville later said that this theory-based exploration had been a valuable part of the therapeutic work.

Conclusion

Despite being developed over 50 years ago, there is an elegance and a succinctness to Rogers' (1951, 1959) theory of personality and development that makes it one of the most persuasive accounts available, as evidenced in its continued inclusion in major textbooks on personality and psychology (see, for example, Glassman, 2000; Pervin & John, 1997). Psychological evidence is now providing much-needed support for this theory and, along with critiques and reformulations from within the person-centred field, is helping to ensure that person-centred development and personality remains contemporary, vibrant and of practical value. Theories of personality and

development may never be as central to the person-centred approach as they are to more diagnostic and analytical psychotherapies, but they have enormous potential to stimulate our questioning and understanding about the nature of our clients' lives – helping us to engage with our clients in a way that is open, non-dogmatic and deeply respectful of the paths by which they have come to be who they are.

Points for reflection

- What is your own, personal, understanding of how people come to be the way they are? Why do you think some people experience severe psychological distress?
- To what extent can your own personality, and developmental journey, be understood in terms of Rogers' classical model? Do the contemporary relational and self-pluralistic perspectives add to, or detract from, this understanding?
- In what ways do person-centred theories of personality and development help you to understand some of the difficulties that your clients are experiencing? How might you bring this into the therapeutic work, if at all?
- To what extent is it necessary to understand person-centred theories of personality and development in order to practise person-centred therapy?

Key readings

- Patterson, T. G., & Joseph, S. (2007). Person-centred personality theory: Support from self-determination theory and positive psychology. *Journal of Humanistic Psychology, 47*(1), 117–39.

An excellent introduction to the contemporary evidence supporting Rogers' model of personality and development.

- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

See especially Chapter 11: 'A theory of personality and behaviour', which contains Rogers' classic set of 19 propositions.

- Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of science* (Vol. 3) (pp. 184–256). New York: McGraw-Hill.

The most comprehensive, detailed and precise account of Rogers' theory of development.

- Sheldon, K. M., & Kasser, T. (2001). Goals, congruence, and positive well-being: New empirical support for humanistic theories. *Journal of Humanistic Psychology, 41*(1), 30–50.

Another valuable review of contemporary empirical evidence in support of humanistic/person-centred theories.

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9
A person-centred perspective on spirituality

MARTIN VAN KALMTHOUT

This chapter discusses:

- Rogers's struggle with spirituality
- Brian Thorne's ground-breaking work on spirituality in person-centred therapy
- Whether spirituality adds anything of significance to person-centred therapy
- The conditions under which spirituality can be part of person-centred therapy, without affecting its identity
- How we can describe the spiritual in person-centred terms
- Implications for therapeutic practice

Within the person-centred community, spirituality is a controversial subject. Some person-centred therapists think that person-centred therapy and spirituality are incompatible and reject any linkage between the two, afraid of person-centred therapy being subjugated to indoctrination by religions, churches, gurus and other spiritual leaders. Such a position is considered irreconcilable with the autonomy of the person, which is the main aim of person-centred therapy (Van Belle, 1990). Other person-centred therapists are of the opinion that religious traditions, for example Christianity, or non-religious spiritual paths, for instance Zen-Buddhism, should play a role in the theory and practice of person-centred therapy. These traditions are supposed to add something extra to person-centred therapy that is missing and that could well enrich it.

Still another view of the relationship between person-centred therapy and spirituality considers person-centred therapy itself to be a spiritual path instead

of a therapeutic method. The advantage of this point of view is that no external belief system is added to person-centred therapy. In this way, the argument that spirituality forms a threat to identity in person-centred therapy is disposed of. What is more, the latter view concurs with Rogers' later development in which he describes his approach as first of all a way of being, and it is for that reason consonant with his basic philosophy.

In this chapter, I pay attention first of all to Rogers' specific view of spirituality and then to the original interpretation of that perspective by Brian Thorne. More than anyone else, Thorne is a pioneer on this subject who has explored the field in a ground-breaking way. Within the limited space of this chapter, it will not be possible to treat the contributions of all the other person-centred therapists who have explored the spiritual dimension of person-centred therapy, but some will be briefly mentioned, and relevant literature to study them will be given. The aim here is to present a person-centred perspective on spirituality that is based mainly on Rogers and the original interpretation of his work by Brian Thorne.

Rogers' struggle with spirituality

To fully understand Rogers' view of spirituality, we first of all have to grasp that his break with the Christian faith is very important in this context. As is well known, Rogers grew up within a rather strict version of the Protestant-Christian faith. Soon he encountered variants that were more liberal, and the attraction he felt to these led to an alienation from his parents. This was deepened when he started training as a minister, choosing, against the will of his father, a more liberal instead of the fundamental education his father preferred. And this was only the beginning. Rogers went a step further in terminating the latter prematurely, being unable any longer to comply with the fixed doctrines he would have to preach as a clergyman (Kirschenbaum, 2007).

These steps were of great personal significance to Rogers. They liberated him from the bonds of Christian faith, enabling him to follow his own course in which personal experience, and not any superimposed system, would be his guiding principle (Van Belle, 1980). Thus, Rogers had not only broken away from his parents and from the Christian faith, but had also established the basis for the philosophy of living he was to develop. It is important to note that Rogers never reconsidered his decision to break with the Christian faith, and that, to the end of his life, he deemed anything related to Church-based religion to be irreconcilable with his personal philosophy of living.

A second aspect of Rogers' life work is important in this connection. At a certain point, he started to regard his approach as a practical philosophy of living, *a way of being*, and no longer a method of therapy. This change can most clearly be seen in his last book, *A Way of Being* (Rogers, 1980). He writes for example: 'I found that I had embarked not on a new method of therapy, but a sharply different philosophy of living and relationships' (Rogers, 1980, pp. 37–8).

It is striking that Rogers presents the new view with great emphasis and deep conviction rather than as an aside. It apparently concerns a fundamental matter and

not just a minor consequence of his approach. This is important because Rogers thus localizes his approach in the domain of the philosophical and not the religious (see Chapter 5), and more specifically in the field of *practical* philosophy of living rather than the domain of theoretical philosophy. We can safely conclude that Rogers thus positions his approach in a domain different from a limited view of scientific psychology such as has been dominating our universities for the last decennia.

Within this context, a third phenomenon in Rogers' development is of importance. Despite his breach with religious faith and the Church, he embarked towards the end of his life on a search for a form of the religious separate from church, faith and religion. Although at first reluctant to use the terms 'spiritual' and 'spirituality', he was later to use them regularly. This term had to ensure that he was not speaking of Church-based religion, but of a kind of religiousness that was experiential, personal and existential. Rogers expressed this in a famous quote: 'I'm too religious to be religious' (Baldwin & Satir, 1987, p. 50).

In this phrase, Rogers made it clear that a break with organized religion did not necessarily imply that the religious as personal experience must be abandoned, the latter even being of higher quality than the former. Rogers thought that, in his approach, this spiritual dimension received less attention than it deserved (Rogers, 1980). Yet he remained wary that he might be wrongly understood. Rogers provided the following answer to a question put to him towards the end of his life on what the influence of the spiritual might be on psychotherapy: 'I would put it that the best of therapy leads to a dimension that is spiritual, rather than saying that the spiritual is having an impact on therapy' (Baldwin & Satir, 1987, p. 35).

This quotation witnesses Rogers' concern that even the so-called spiritual can assume the form of an external system of faith that would have the same disastrous impact on the autonomy of the individual as did the old religions. He states that the spiritual must not be sought outside his approach, but within it, that is to say, there where it is at its best.

The question is, however, what exactly does Rogers mean by spirituality or the spiritual in a more concrete way and in therapeutic practice? To grasp this, we should first consider the therapeutic relationship and more especially a specific characteristic of it that Rogers terms *presence*:

> When I am at my best as a group facilitator or as a therapist, I discover another characteristic. I find that when I am closest to my inner, intuitive self, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing. Then, simply my *presence* is releasing and helpful to the other. (Rogers, 1980, p. 129)

According to Rogers, the spiritual has to be looked for in the profundity of the therapeutic relationship. If such a relationship exists, a spiritual experience can occur, spiritual being defined as being part of something larger than ourselves. It is remarkable that, in this context, Rogers refers for the first time in his approach to *transcending the self*. For Rogers, the autonomy of the individual, of which he is the

staunchest advocate, in no way conflicts with transcending 'the self'. After all, the self here is the conditioned, neurotic self that Rogers calls the *self-concept*, and not the *organismic self* that forms the nucleus of the autonomous person.

Rogers also points to another implicit spiritual dimension of person-centred therapy, namely our relationship with the cosmos. On this subject he says:

> Thus, when we provide a psychosocial climate that permit persons to *be* – whether they are clients, students, workers, or persons in a group – we are not involved in a chance event. We are tapping into a tendency that permeates all of organic life … I believe we are tuning in to a potent creative tendency, which has formed our universe. (Rogers, 1980, p. 134)

Contrary to what is common in the psychotherapeutic world, Rogers refers here to a domain different from the individual and the relational, namely to our relationship with the cosmos. There is not only the *actualizing tendency* within the individual, but also the *formative tendency* operating in the universe. Once we have reached a certain depth of *being*, we are in contact with everything that *is*. The most personal is also the most universal.

Briefly summarized, then, in Rogers' view the spiritual is unrelated to the Church or to any other form of organized religion, but is rather to be found in the profundity and quality of the things we as person-centred therapists already perform, in what is best in our approach.

The pioneering work of Brian Thorne

In contrast to that of Rogers, Brian Thorne's work on spirituality is founded on his personal mystical experiences. Rogers was always very clear that he never had any such experiences, whereas Thorne had already experienced them as a child, and these were a crucial influence on his later life and work. One of these experiences took place on Good Friday 1946, when he was 8 years old. In his autobiography *Love's Embrace* he writes:

> I have no hesitation in stating that in those moments my life was changed for ever and that whatever has happened to me subsequently and all I have learned since is but a confirmation and an amplification of the truth that entered into the very fibre of my being on Good Friday, 1946. (Thorne, 2005, p. 10)

Another difference between Rogers and Thorne is that the latter remained a convinced Christian all his life, and although he criticized organized religion, he was a faithful member of the Church of England. For him, there is no tension between the essence of person-centred therapy and the core of Christian belief. He is of the opinion that Rogers was the victim of a perverse kind of theology and was therefore not able to see that, essentially, person-centred therapy and Christianity share the same values. In other words, according to Thorne, Rogers was fighting an incorrect image of Christian faith.

Thorne nevertheless found Rogers to be on the right track in his later spiritual journey, but deplored the fact that it did not bring a definite breakthrough. While Rogers was doubting and hesitating until the end, for Thorne it was absolutely clear that person-centred therapy was the vehicle through which the essential Christian values were made accessible to the modern world:

> Fifty years from now it is likely that Rogers will be remembered not so much as the founder of a new school of psychotherapy but as a psychologist whose work made it possible for men and woman to apprehend spiritual reality at a time when conventional religion had lost its power to capture the minds and imaginations of the vast majority. (Thorne, 1992, pp. 105–6)

Brian Thorne is one of the most outspoken adherents of the view that person-centred therapy is first of all a spiritual discipline. A passionate elaboration thereof is given in his book *The Mystical Power of Person-centred Therapy* (published in 2002), in which a central thesis is that, from the beginning, a covert spiritual thread was present in Rogers' work, even though he himself was not aware of it.

What, then, does such a spiritual discipline imply in concrete terms, according to Thorne? To start with, we should be aware of the fact that this discipline is very demanding and goes much further than a superficial application of the core conditions:

> The core conditions … are, in fact, an invitation to embrace a way of being which demands not less than everything. The commitment to constant self-exploration and self-awareness which is the prerequisite for the genuine expression of the self (congruence), the dedication to the expressed understanding of the other's world (empathy) and the ability willingly to accept unconditionally the other person … (unconditional positive regard) – this is the disciplined agenda of a lifetime. (Thorne, 2002, p. 4)

Although he is a faithful Christian, Thorne states that person-centred therapy as a spiritual discipline does not know any dogmas, gurus and spiritual exercises, and that it is not even important whether we express ourselves in spiritual or existential concepts. The only thing that counts is the willingness 'to meet at relational depth and for one to be thoroughly schooled in the practice of offering the core conditions to herself and to the other who seeks her help' (Thorne, 2002, p. 5).

According to Thorne, person-centred therapists should be aware of the fact that, through their work, they contribute to a better world. They are the representatives of the light in the darkness of a world that becomes grimmer every day. The core of this spiritual discipline is 'self-love', which is the necessary condition for a loving attitude towards others, the world and the cosmos. One should keep in mind though that self-love should not be mistaken for narcissism or egocentrism.

Brian Thorne's in-depth and passionate study of Rogers' work has brought us a radical and original interpretation of it, one that has received much enthusiasm as well as criticism, especially from those person-centred therapists who consider it a danger to the professional and scientific stature of person-centred therapy.

Other approaches

Peter F. Schmid has created an extensive oeuvre directed at the theoretical and philosophical underpinning of Rogers' work (see Chapter 5). In this, he has been inspired by the work of the philosophers Martin Buber and Emmanuel Levinas, among others. Interpersonal dialogue is the essence of Schmid's work; the depth of his studies of relationship might contribute considerably to the development of a person-centred view of spirituality (Schmid, 1998).

The experiential and focusing approach to spirituality seems very promising. Mia Leijssen, for example, made a plea for revitalizing the concept of soul (Leijssen, 2009). Similarly, philosopher Cambel Purton (2004, 2010) made an original contribution to the experiential approach to spirituality by delineating a way to experience 'the truth beyond concepts', inspired by the 'doctrine of mystery' developed by philosopher David Cooper, as well as by Gendlin's theory.

The subject has also been approached from Christianity, not only by Brian Thorne, but also by Schmid (2006), further from Zen-Buddhism and the mystical tradition (Ellingham, 2006). An overview of the variety of other approaches and contributors can be found in the book from a Conference on Spirituality and Counseling held in Norwich (Moore & Purton, 2006).

Spirituality in a secular era

Rogers did not thoroughly elaborate his ideas on the spiritual at the same high level as the rest of his approach. We rather consider them as brief hints, yet they do indicate a direction and can be a source of inspiration to us. Building on them, we can work on a consistent person-centred approach of the spiritual.

Living in a secular era, the challenge is first and foremost to express the secular character of the person-centred approach to the spiritual. Rogers' life and work are an expression of secularization and of emancipation from religious oppression and authority. At their root lies a secular philosophy. This means we have to look for a secular spirituality, maybe even an atheistic spirituality, which indicates a spirituality without Church, dogma, religious rituals, heaven and hell, even without God (Billington, 2002; Bonhoeffer, 1954; Krishnamurti, 1992).

At first glance, this may seem peculiar, but in fact it is not as strange as it seems. In the mystical tradition, it has often been pointed out that one must leave God behind in order to find him. Faith in God is in the first place a projection of ourselves to make our fundamental loneliness bearable. It is an expression not of authentic spirituality but of fear. We created God and not the other way around. Therefore, it is extremely important in a person-centred approach to explore the psychological roots of the spiritual before we can discuss authentic spirituality.

A further characteristic of a person-centred approach to spirituality should be the central position of the personal, the experiential and the existential, rather than the dogma imposed from outside, whether this be from the Church, the New Age move-

ment or any other religious or spiritual organization or direction. This coincides with an ancient distinction – already made by William James – between religious experience and organized religion. Spiritual or religious experience is a universal human faculty, which therefore fits within the domain of person-centred therapy. It concerns the unbiased search for what is true, not the repetition and execution of external religious truths and prescriptions. It concerns experiencing and living through uncertainty rather than suppressing it through external pseudocertainties. It requires openness to the unknown, to the mystery, an attitude of *not knowing* and questioning without expecting immediate answers. It also implies that what we are looking for will never be completely found or definitively expressed in words.

Central here is a realization of the limitation of our knowledge and learning to live with the mystery. There is a direct connection here to the mystical tradition (Ellingham, 2006). This fits well with a person-centred approach because it stems from the deep realization that it transcends all our words, concepts and images. So it is not a solution for want of a better one. It is instead a fundamental restraint in giving content to the spiritual with words and images that are above all expressions of our own needs and desires (projections), which by definition miss the point where the essence of the spiritual is concerned. Although this may seem obvious, it is an essential principle for a person-centred approach of the spiritual.

Based on our philosophy, we have no definitive description of the spiritual, as is found in organized religion. What we do have is a respecting, empathic and authentic approach of reality. This enables us be open to the big questions of life, and to help our clients in their quest for the answers to these questions. If we observe the conditions described above, we as person-centred therapists are able to concern ourselves with the spiritual in a congruent and consistent way, without belying our natures and without compromising our fundamentally scientific attitude.

Therapeutic practice

In therapeutic practice, the spiritual as described above is not immediately present (for example in the form of certain techniques, exercises or rituals), but it is implicit in our practice as a possibility. That is to say, it lies in the fundamental attitudes of the therapist and in the depth of the therapeutic process of change. Often explicitly present, though, is the question of the meaning of life, a question the spiritual in principle is trying to answer. Seldom is this question 'the presenting problem', but sooner or later it will arise, sometimes quite explicitly, sometimes implicitly. This can be the case with all kinds of clients and with various complaints. But the shared undercurrent is often a feeling of uselessness, of somberness or depression, of helplessness or hopelessness, and in this way it is also the expression of a desire for meaning.

Take, for example, the category of clients with work-related problems and burnout. At first sight, these problems do not seem very profound. That is why there is a large number of protocols, courses and short-term therapies on the market, competing among themselves for which is the fastest and most effective. It is my experience

that these problems can be highly existential, often being the result of a crisis in the client's life. This can make the question of the meaning of his or her life very real. In a number of cases, this question may turn out to be very fruitful as it can lead to new meaning and depth of existence. The question is, where does the spiritual dimension lie in these cases?

To begin with, it can be found in the client's process of change. Some clients, for example, might say they have become another person, having a different view of life, finding other things important than they did before the crisis. Some may even say that their lives have become more spiritual. At the same time, the term 'spiritual' is not important. We can easily do without it; sometimes it is even harmful.

Whether or not the deepening to a spiritual dimension occurs may depend on the profundity of the therapist's presence in relation to the client. The spiritual dimension lies in the quality of his presence in terms of the client's quest for meaning. If the therapist is not open to this dimension, there is less chance that the client will experience it. If the therapist has no affinity with the client's quest, the change process may remain superficial because the client will sense that, in this respect, the therapist is the wrong person.

The same might be true for the growing group of clients who are struggling with their traumatic past and how this has definitively coloured their lives, or has even destroyed it. For this problem, it is also true that there are all kinds of technical and solution-focused therapies, but these are again insufficient for many clients. They want to explore and work through the depth of their lives and are looking for new meaning in spite of what they have experienced. The manner of presence of the therapist can play a crucial role in this process. Here also, we might speak of a spiritual dimension, especially where it concerns hope in the face of meaninglessness and despair (Thorne, 2002).

There are more examples, and everyone can find them within his or her specific setting, for example with serious psychiatric disease. There, the patients' suffering is often so hopeless that assistance can take no other form than *being present at* the suffering of these patients and respecting them as human beings (van Blarikom, 2006). Rogers' term *presence* concretely indicates what the depth of the relationship means here. Involvement in the patient's suffering is one of the main issues, without there being any concrete action to be taken or there being any cure in view. Depth in the therapeutic process and in the therapeutic relationship is key where the spiritual dimension of person-centred therapy is concerned.

In this connection, I would like to point to another concrete aspect of spirituality, one directly connected to Rogers' emphasis on the importance of regarding person-centred therapy as *a way of being*: the development and practising of *inner discipline*. This concerns something that receives too little attention in therapeutic settings, but all the more in spiritual approaches.

Many clients experience difficulty in putting into practice in their daily lives – in a disciplined way – the things they have learned in therapy. We might say that they do not concern themselves enough with changing their way of living or their relation-

ship with life, working at it with full attention minute by minute. This is often trained and practised in meditative approaches such as Zen meditation. It is highly possible to teach this to our clients in our own approach by way of *focusing* (Purton, 2004). Because this concerns an attentive focusing on the meaning of everything we encounter in daily life, both within ourselves and around us, we can speak of an existential and even spiritual dimension. We take upon us the task of bringing depth and quality to our lives, to live life to the full and to turn our attention inside. An implication of embracing the approach as a spiritual way of being is that this should be reflected in training for person-centred therapists (Thorne, 2012).

Conclusion

Spirituality in person-centred therapy does not demand from us that we work in different ways than we already do or that we introduce specific insights or methods from other disciplines, but that we practise the best we have available, allowing the client to share in this. Spirituality has something important to contribute to therapy, namely that we are and do what is the best in our approach. I do not hesitate to say that if spirituality means anything at all, it can be found in the essence of person-centredness: empathy, unconditional love and authenticity (Van Kalmthout, 2006). By calling these spiritual, we will want to *be* and practise them at the deepest possible level, and not be tempted into a reductionist view that will impoverish reality and turn our approach into the continuation of a limited view of man. This is the person-centred definition of spirituality.

Points for reflection

- Do you think that the spiritual should have a place in person-centred therapy? If so, what would this imply, theoretically as well as practically?
- What exactly do you mean by spirituality? Do you follow a certain spiritual path? If so, how does this influence your therapeutic work?

Key readings

- Kirschenbaum, H. (2007). Spiritual journey. In *The life and work of Carl Rogers* (pp. 477–91). Ross-on-Wye: PCCS Books.

An excellent overview of Rogers' struggle with spirituality, provided by his biographer Howard Kirschenbaum.

- Moore, J. and Purton C. (Eds.) (2006). *Spirituality and counselling. Experiential and theoretical perspectives*. Ross-on-Wye: PCCS Books.

An overview of present-day person-centred approaches to spirituality.

■ Rogers, C. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Rogers's most important book as far as spirituality is concerned.

■ Thorne, B. (2002). *The mystical power of person-centered therapy. Hope beyond despair*. London: Whurr.

Of the many writings of Brian Thorne, the most appropriate in this context.

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Part II

Therapeutic practice

Edited by Arthur C. Bohart

In this section, we consider aspects of therapeutic practice. For the person-centred therapist, it could be said that the therapist *is* the therapy, although, perhaps more accurately, one could say that the *relationship* between therapist and client is the therapy. From the therapist's point of view, it could be said that the therapist's way of being is the method. Carl Rogers identified six basic conditions that had to be present for therapy to work (see Chapter 2). Two of these conditions, covered in Chapters 12 and 16 in the first edition of this book, focus on the client. Rogers hypothesized that clients needed to be in a state of incongruence. That is, there had to be a conflict between their self-concepts and their organismic experiencing in order for therapy to work. In addition, they needed to perceive the positive relational conditions being offered by their therapists.

The four conditions considered in this section – contact, empathy, unconditional positive regard and congruence – relate to the relationship. Rogers postulated that therapists and clients needed to be in psychological contact in order for therapy to work. Gill Wyatt elaborates on what this means in Chapter 10. In addition, therapists needed to be able to understand clients' experiences from their point of view. In other words, therapists needed to experience empathic understanding. Elizabeth S. Friere considers this quality in Chapter 11. Therapists also needed to experience unconditional positive regard for their clients, as Jerold D. Bozarth elaborates on in Chapter 12. Finally, therapists have to be in a state of personal congruence in therapy. This concept, often misunderstood, is discussed by Jeffrey Cornelius-White in Chapter 13.

These chapters are then followed by a new chapter on therapist presence. Late in his life, Carl Rogers said that he thought that presence might be the most important element in therapy. As elaborated on by Shari Geller in her chapter, presence is a therapeutic quality that is a component of unconditional positive regard, empathy and congruence. Presence is also discussed in the chapters on congruence, by Cornelius-White (Chapter 13), and on groups, by Peter F. Schmid and Maureen O'Hara (Chapter 15).

Two chapters on specific modalities of doing psychotherapy and counselling follow. Although one could say that, ultimately, the therapist is the therapy in the person-centred approach, there are qualities unique to specific modalities of practice (see Part III for a consideration of working with specific populations). Chapter 15 by Schmid and O'Hara discusses doing person-centred therapy in a group format. Basically, for them, the *group* is the therapist. This chapter also considers some of the implications of group work beyond psychotherapy and Rogers' work with groups outside traditional therapeutic settings. Next, in Chapter 16, Natalie Rogers describes her person-centred expressive arts approach. Built on basic person-centred principles, Rogers has developed a format of integrating a variety of artistic modalities, including artwork, dance, music and poetry, to help clients find their best ways of growing.

Finally, David J. Cain provides Chapter 17 on psychotherapy integration from a person-centred point of view. The topic of person-centred psychotherapy integration is controversial, and this chapter will be too. There are many in the person-centred movement who believe that to move away from a basic, traditional, empathy-following modality of doing person-centred therapy is to corrupt it. What gets lost, from their point of view, is the basic quality of non-directivity, with a consequent disempowerment of the client (see Chapter 4 for a discussion of this). However, there have been a number of authors who have argued for various versions of integrating approaches and procedures into a person-centred practice. In Chapter 17, Cain reviews these efforts from an integrative point of view, including his own, and Natalie Rogers' expressive arts approach, as well as controversial approaches such as Gendlin's focusing-oriented therapy, and the process-experiential/emotion-focused approach.

10
Psychological contact

Gill Wyatt

This chapter discusses:

- Rogers' theory of psychological contact
- Psychological contact and Pre-Therapy
- Two further conceptualizations – a relational and a holistic/emergent view of contact
- Contact in practice: psychological contact with contact-impaired relationships, psychological contact in person-centred relationships, and psychological contact in holistic/emergent relationships

I looked forward to seeing her; there was an ease and flow between us, even when exploring a difficulty between us. I always felt more alive at the end of our session.

The client was silent for 20 minutes, staring at the ground; she seemed to not hear the occasional comment I made about her silence, our situation or what I was experiencing.

The way she looked at me did something to my innards. It was as if her need was so great that she would be able to suck the life out of me.

In these vignettes, therapists describe experiences of their contact with clients. The everyday understanding of contact is 'to touch', 'to meet' and 'to communicate'. Do these vignettes describe psychological contact? In this chapter, the evolving nature of psychological contact and its central concepts are explored in order to discover what significance psychological contact has for person-centred practice. This exploration includes Rogers' original conceptualization and three further conceptualizations – Garry Prouty's psychological contact and Pre-Therapy, a relational conceptualization, and a holistic/emergent conceptualization.

A *multiple perspective* view of psychological contact results in which each conceptualization has a part to play in developing our person-centred practice.

The central concepts

Rogers' psychological contact

Rogers, in his 1957 and 1959 statements, described the critical elements of a therapeutic relationship. The first of these necessary and sufficient conditions for therapeutic personality change he calls 'contact' and 'psychological contact', using these two terms interchangeably. Rogers states that 'two persons are in psychological contact, or have the minimum essential relationship when each makes a perceived or subceived difference in the experiential field of the other' (Rogers, 1959, p. 207). Psychological contact is therefore synonymous with 'a minimum essential relationship' in which each person makes a difference to the experience of the other. Rogers highlights the extremity of the 'minimality' of relationship and clarifies the role of 'subceived differences' where 'the individual may not be consciously aware of the impact' (1957/1990, p. 96) by referring to a 'catatonic' patient as being able to perceive or subceive the presence of the therapist at 'some organic level' (p. 96).

Rogers reveals that, at first, the term 'relationship' was used. This, however, led to the construct being misunderstood and taken to mean 'the depth and quality of a good relationship' (Rogers, 1959, p. 207). Rogers clarifies that 'the present term [contact] has been chosen to signify more clearly that this is the least or minimum experience which could be called a relationship' (p. 207).

For Rogers, the central concepts in psychological contact are relationship, experience and perception. Rogers' meaning of psychological contact involves two people making some difference to each other whether they are aware of it or not. He concluded that 'this first condition … is such a simple one that perhaps it should be labelled an assumption or a precondition'. He explained that it should be considered as 'an assumption or a precondition *in order to set it apart from those that follow*' (1957/1990, p. 96, emphasis added). It is perhaps surprising that Rogers did not focus on psychological contact again considering he also said that, without psychological contact, the other five conditions 'would have no meaning' (p. 96).

A further differentiation was made within Rogers' six conditions that have affected the significance of contact in person-centred theory, practice and research. Three of Rogers' conditions – empathy, congruence and unconditional positive regard (UPR) – were initially considered as the 'therapist provided conditions' (Watson, 1984, pp. 21–4), and then later referred to as the 'core conditions' (Mearns & Thorne, 1988, p. 15). The majority of attention has been given to an examination of these conditions. In contrast, the remaining conditions were called the 'implied conditions' by Raskin and Rogers (1989/2000, p. 263), who described conditions one (contact) and two (client incongruence) as the 'preconditions for therapy' (p. 264). Tudor (2000) has referred to these 'implied conditions' as the 'lost

conditions'. Not surprisingly, the trend in person-centred research regarding psychological contact has been at best to assume psychological contact and at worst ignore it (Barrett-Lennard, 1962, 2002; Watson, 1984).

The evolving nature of psychological contact

This trend of paying little attention to contact continued until the renewed interest in psychological contact that emerged in the 1990s with Garry Prouty's work on Pre-Therapy (see Chapter 22) and a more recent shift in interest to all of the six conditions from the 'core conditions'. Psychological contact received further attention as a result of this shift (see Wyatt & Sanders, 2002).

Psychological contact and Pre-Therapy

Garry Prouty (1994/2002) developed his theory of psychological contact and Pre-Therapy as a result of his experiences with clients who seemed to be unreceptive to Rogers' client-centred therapy (Prouty, 1994/2002, p. 55). These clients were unable to establish the minimum relationship required for Rogers' condition of *contact* to be met. Prouty coined the terms 'pre-relationship', 'pre-experiencing' and 'pre-expressive' to describe an individual who has no coherent 'self' to process experience, acknowledge the other and communicate with reality (see Chapter 22). Drawing from Gendlin's concept of 'experiencing' (1962) and gestalt psychotherapy, he extended Rogers' singular concept of contact to encompass three aspects – contact functions, contact behaviours and contact reflections. Psychological contact, then, is defined as 'the concrete awareness of reality (people, places, events and things), of affective states and the ability to communicate about this in a congruent and understandable way' (Van Werde, 1998, p. 199). The goal of Pre-Therapy is therefore to help clients become able to process experience, become 'expressive' and develop or restore the ability to be in psychological contact.

Garry Prouty and his associates in the Pre-Therapy International Network have carried out numerous successful research projects demonstrating the effectiveness of Pre-Therapy in establishing or improving psychological contact (see Chapter 22).

Discussion and further conceptualizations

The Pre-Therapy definition of contact involves a 'concrete awareness' of reality and affective states and communication. Rogers' definition involved a minimal relationship in which each person made some 'perceived' or subceived' difference to each other. Margaret Warner points out how more 'elaborated', 'reality orientated' and 'process-rich' the Pre-Therapy definition is (2002, p. 79). The difference between these two conceptualizations is profound. Pre-Therapy's contact emphasizes concrete awareness, whereas Rogers' nearly minimizes awareness by introducing the concept 'subception' as this is discrimination without awareness (Rogers, 1959, pp. 199–200). This means that Pre-Therapy's contact has a higher threshold than Rogers' original

conceptualization. With Rogers' definition, contact was 'always present' at the minimal level he referred to, as suggested by Dion van Werde: 'the Rogerian thinking … almost presupposes contact *as continuously present*' (2002, p. 172, original emphasis).

Embleton Tudor et al. arrive at a different position, asserting that 'psychological contact is a digital or binary phenomenon. Two people are either in psychological contact or they are not. It is not a matter of degree' (2004, p. 39). This suggests that with contact present, therapists will be able to provide the 'therapist conditions' and clients will be able to perceive them, whereas when contact is absent, the 'therapist conditions' become ineffective. The significance of Pre-Therapy is that it provides a theory and specific practice for when psychological contact is impaired.

In considering the nature of contact, Rogers's conceptualization possesses some ambiguity. If contact is a precondition necessary for the other five conditions to be effective, this could support seeing contact as a binary event. This is the psychological contact of Pre-Therapy and Embleton Tudor's interpretation, in which psychological contact is made or not made. However, if contact is an assumption or is continually present, it becomes a minimal event that describes the relational nature of our existence in which people make perceived or 'subceived' differences to each other all of the time.

A further suggestion from Whelton and Greenberg and Warner is that contact is a continuum. Whelton and Greenberg (2002) point out that Rogers saw all his other conditions as a continuum (Rogers, 1959). Neither describes the detail of the continuum, but when Warner suggests that minimal levels of psychological contact would be sufficient for Rogers' therapist conditions to work to some degree (2002, p. 79), she might be implying that this would be towards one end of the continuum. Beyond this might be the relationship between the 'contact-impaired', 'pre-expressive' client and therapist undertaking Pre-Therapy, while perhaps the other end might be the psychological contact of 'presence' (Rogers, 1980), 'depth of contact' (Cameron, 2003) and 'relational depth' (Mearns & Cooper, 2005).

This exploration of psychological contact as being 'continually present', a binary phenomena or a continuum, can be understood in relation to different ontological (nature of reality) and epistemological (knowledge system) frames. Ivan Ellingham has stated that Rogers' theory is critically flawed because the theory belongs to the emerging organismic and holistic scientific paradigm whereas its foundational concepts 'are not congruent representations of this emerging paradigm but of the Cartesian-Newtonian paradigm that it supersedes' (2002, p. 234). Ellingham elucidates that, in Rogers' theory, experience, awareness and perception are given a quasi-Cartesian-Newtonian 'thing-like' quality as a 'pre-existing label' is attached via symbolization 'to an already existing feeling, experience or perception' (p. 242).

The nature of psychological contact changes according to whichever ontological/epistemological frame it is experienced and viewed through. Within the Cartesian-Newtonian frame, psychological contact will involve two separate and bounded selves situated in a 'one reality' and 'one truth' universe. Here the effect of one person on another involves unidirectional causality as in one person doing something to the

other person to achieve a specific effect, for example making a diagnosis and delivering a specific treatment. However, as well as Rogers' concepts having this 'thing-like' quality, a more organismic/holistic frame is also demonstrated when Rogers' psychological contact involves a mutually perceived or subceived 'difference in the experiential field' (1957/1990, p. 96). This describes the relational nature of an interconnected existence. His conceptualization of psychological contact therefore straddles the Cartesian-Newtonian and organismic/holistic frames.

Warner and Ellingham both present Gendlin's 'bodily felt sense' to replace the 'thing-like', 'pre-existing phenomena', as this offers a more process-based foundation for perception and experience. The 'bodily felt sense' is a 'holistic, unclear sense … of a whole situation' at the edge of our awareness (Gendlin, 1984, quoted in Ellingham, 2002, p. 241).

Drawing from Gendlin and evolutionary psychology, Warner (2002, p. 80) offers an expanded definition of 'psychological contact': 'it is a fundamental adaptation of the human organism that allows human beings to feel that they are meaningfully present both verbally and non-verbally to themselves and each other'. Warner's 'adaptation' means a process that fits with the environment in which it is located. The nature of psychological contact is now *relational*, *contextual* and *a process* characterized by the 'meaningful presence' of the self, meeting with another's 'meaningful presence'. Meaning acts as the interface between individuals and culture. Warner's conceptualization offers more cultural sensitivity than others. This is significant when considering cultural differences and how these differences affect the way in which psychological contact is made and is experienced (see Davies & Aykroyd, 2002).

With this shift away from the Cartesian-Newtonian frame, the world extends to become qualitative as well as quantitative (Reason & Goodwin, 1999). Whelton and Greenberg (2002) emphasize this qualitative nature of psychological contact when they state that it is the 'degree or quality of contact that is important' (p. 97). Rose Cameron (2003) agrees when she suggests that it is the degree of psychological contact that determines the depth of the relationship: 'The depth of contact is what makes the difference between a rather mechanical and lifeless therapeutic relationship and one that shimmers with energy and involvement' (p. 87).

This more relational conceptualization of psychological contact, which emphasizes the qualitative nature of contact, involves multiple dimensions and processes. Maureen O'Hara describes psychological contact as a 'dynamical process, which is contextual, relational and emergent' (personal communication, 2006). This more emergent, qualitative nature of contact requires a radical reformulation of concepts. Ellingham provides a step in this direction when, in discussing perception, he refers to organisms as being 'fields of activity' that are also part of larger fields. Perceptions, experiences and feelings, rather than having a 'thing-like' existence, are now 'felt aspects of the field of activity' (2002, p. 244).

The nature of psychological contact now becomes a changing qualitative felt sense that results from any activity within the field of the client influenced by any activity within the field of the therapist, influenced by any other fields of which they

are a part. The atomism of the boundaried self is replaced by a self, open to the interpenetrative fields of influence from self, others, culture and the organic world. This is akin to the 'interbeing' of Thich Nhat Than (1998). Contact, then, becomes a 'site of emergence' (O'Hara, personal communication, 2006), which would have infinite qualities, so the image of a spiral now replaces the linear continuum. Psychological contact now has a '*co-experienced*', '*co-created*' (Schmid, 2002, p. 196), *participative*, *emergent* nature arising from the interpenetrative fields of influences.

Little psychotherapy research has so far been carried out to support these recent hypotheses. Mick Cooper's research into relational depth (2005) supports Mearns and Cooper's (2005) exploration of 'working at relational depth', which they describe as 'intense relational contact and enduring experiences of connectedness', reporting on the 'striking' significance for the clients involved (p. 1). Shari Geller's research on presence used qualitative research to explore the therapist's reflective experience of presence. She concluded that the therapist's presence is both a necessary precondition for the other conditions and also 'a larger whole, an overarching condition by which empathy, congruence and unconditional regard can be expressed' (Geller & Greenberg, 2002, p. 84).

From theory to practice

The significance of psychological contact for our person-centred practice depends on its nature, and its nature has evolved with each conceptualization. What I am proposing is a multiple perspective view where each conceptualization of psychological contact plays a crucial role in developing our person-centred practice.

Rogers' conceptualization acts like a baseline, applicable to all of our practice. Prouty's psychological contact and Pre-Therapy become invaluable in the close focus needed with 'contact-impaired' relationships. The relational conceptualizations of Warner, Whelton and Greenberg, and Cameron have relevance in person-centred relationships, including those with clients who have fragile and dissociative processes. The holistic/emergent view of psychological contact becomes invaluable, rather like a wide-angle lens, when the wider web of influence is significant and with encounter relationships or relationships at depth. The task for therapists becomes knowing or sensing which conceptualization will inform their practice and when, while not losing the centrality of the client's self-directivity.

Psychological contact with contact-impaired relationships

Psychological contact in 'contact-impaired' relationships will meet Rogers' minimum relationship; however, therapists often experience person-centred therapy as ineffective in that the congruent therapist's empathy and UPR do not seem to reach, touch and be perceived by the client.

The significance of Prouty's psychological contact and Pre-Therapy is that it provides a theory and specific practice for when person-centred therapists find contact 'problematic' or when the therapist feels 'out of contact' with the 'pre-expres-

sive' or 'contact-impaired' client, for instance with diagnoses of schizophrenia, dementia or mental retardation. The therapist has little idea of the clients' experiencing and of their frame of reference. The clients' pre-expressive, psychotically charged communication does not use 'significant symbols that presupposes the other' (Shlien, 1961/2003); the other is not acknowledged. It is precisely this non-acknowledgement of the other that is the central feature of clients who are 'contact-impaired' and experienced by others as 'out of contact'. This in part defines the quality of the psychological contact, which might be described as 'vacant' or 'bizarre'. The therapist can feel disturbed, and this can affect their UPR and capacity to be empathic.

Pre-Therapy contact reflections provide the therapist with concrete empathic responses that facilitate them in maintaining their availability for contact when the usual empathic understanding responses create no bridge of contact between therapist and client. Sommerbeck calls this 'empathic participation' and likens it to 'empathic attunement' or 'empathic mirroring' (personal communication, 2006). The therapist uses contact reflections with the pre-expressive client until 'contact' occurs, by the client acknowledging the therapist in some way. This allows the therapist to shift to empathic understanding (Sommerbeck, 2003).

The dialogue outlined in Box 10.1 is of a client with 'grey-zone functioning' (van Werde, 2002, 2005). This 'is a conceptual category between "healthy" and "severely contact-impaired" functioning' (2002, p. 171). The client's functioning is initially psychotically charged, and the therapist (Sommerbeck, 2005) experiences no basis for an ordinary empathic understanding of the client's internal frame of reference. The dialogue demonstrates a shift in the quality of the psychological contact as the client's contact behaviours improve as a result of the therapist's contact reflections (CR). The therapist experiences that she has 'reached' the client and as a result can empathize with the client's internal frame of reference through empathic understanding responses (EUR). The excerpt in Box 10.1 is from the sixth session of the client's therapy.

Box 10.1

A shift in the quality of a client's contact

(Client moves her head around in abrupt jerks, staring at different spots)

Therapist:	You turn your head this way and that way and look around. (CR)
Client:	(grinding his teeth): My father is Satan.
Therapist:	You grind your teeth and say 'My father is Satan'. (CR)
Client:	He has slaughtered my mother, he is the real Satan, and the Danes are his devils and devils' brood.
Therapist:	He is the real Satan, because he has slaughtered your mother,

and the Danes are his devils and devils' brood. (CR, apart from the 'because' that is a causality assumption from the therapist's frame)

Client: Not all Danes, people here are nice to me, but he has slaughtered my mother and if he does it again I'll slaughter him.

Therapist: You feel you'll slaughter him if … (A mixture of CR ('slaughter him') and EUR ('you feel you'll'))

Client: (interrupts eagerly) Yes, he has terrorized my mother all her life, psychological terror … her name is Maria, if Satan harmed Maria … Joanna would slaughter him, I'm Joanna.

Therapist: You say 'I'm Joanna' (CR) and you feel like you think Joanna would feel if Satan harmed Maria, is that it? (An effort at EUR, but with too much inference from the therapist's frame of reference ('you feel like you think'))

Client: (Nodding her head and smiling): Yes, and I'm not afraid of Satan, I'm not afraid of anything.

Therapist: You smile at the thought that you are not afraid of Satan or … (EUR since an empathic inference is made about the smile and the thought. A CR would have been 'You smile and you say you are not afraid of Satan'.)

Client: (Interrupting) Yes, I'm not afraid, I'm glad of that, but why does he always have to be so rotten, last time he visited he brought some fruit from his back garden; it smelled awful and then I took a bite and it tasted hellish … I threw it all away.

Therapist: You think that everything he brings … (Start of an EUR)

Client: (Interrupting) Yes, why does he have to be so provocative?

Therapist: Like 'Why the hell can't you buy me some good fruit that I like, instead of bringing me the rotten leftovers from your back garden?' (A full blown EUR – here the richness of the therapist's understanding of the client's frame of reference is considerably enlarged. This happens as the client turns to the therapist with a clear wish to understand and be understood ('Why does he …'))

Client: Yes, I think he never spreads anything but shit around him – I can't bear being near him.

(Sommerbeck, 2005, pp. 323–5)

The client spends the rest of the session exploring her relationship with her father in a way that seems more coherent and less infiltrated with psychotic ideation than earlier. The pre-expressive psychotic expression 'My father is Satan' initially has no reality sense or contact, but gradually, through the therapist's contact reflections, the context and referent for the psychotic expression is provided by the client. The client's level of functioning shifts, as does the psychological contact, and as this happens, the therapist shifts from using Pre-Therapy contact reflections to regular person-centred therapy. The implication for the therapist is to develop sensitivity to these shifts in psychological contact and be able to move from Pre-Therapy contact reflections to person-centred therapy.

Psychological contact in person-centred relationships

For the majority of person-centred therapists, most sessions will be with clients where psychological contact exists between client and therapist in relation to both Rogers' and Prouty's conceptualizations. Rogers' baseline is maintained and psychological contact could be seen as simply the container for the congruent therapist's empathy and UPR.

Warner (2002), Cameron (2002) and Whelton and Greenberg's (2002) explorations mean that there will be varying degrees and qualities of psychological contact, for example 'hesitant', 'intense', 'prickly', 'collaborative', 'uneasy'. These different qualities of psychological contact emerge from the meeting between:

- the 'self-organization' of the therapist (congruence);
- the 'self-organization' of the client (client incongruence);
- the cultural context.

Some client-centred therapists (for example, Bozarth, personal communication, 2006) would say that the quality of psychological contact is created by the therapist's congruent empathy and UPR. This is true – but it is not the whole picture. The therapist and client's availability and receptivity to meet, touch and know the other will influence the contact between them. This influences the therapist's congruence and ability to be empathic and have UPR, as well as the client's perception of the therapist's empathy and UPR. The degree and quality of the therapist's psychological contact will also ebb and flow in relation to the client's process, the nature of material being presented and any cultural difference. The client responds to how the therapist responds, and then the therapist responds to how the client responds.

Embracing a relational view of psychological contact will mean that paying attention to the changing quality of psychological contact becomes *central* in person-centred practice as it influences our congruent empathy and UPR and how these are perceived by the client. How we respond to our clients now shifts from very sensitive empathic following, as with a client in fragile process (see Chapter 23), to empathic understanding or to a more dialogic encounter, as determined by the quality of contact (Box 10.2).

Box 10.2

The changing quality of psychological contact: an illustrative hypothetical example

The session is difficult. The therapist has struggled to communicate her UPR through her empathic understanding, and the client, even though she usually experiences her therapist's genuine empathy and UPR, feels both lost and irritated. Twenty minutes into the session, she hesitantly says, 'I don't know …' and then pauses.

If the quality of the psychological contact is 'fragile', the therapist might respond with sensitivity saying, 'You don't know and then you've paused.' If the quality of the relationship is more characteristic of 'ordinary' person-centred relationships, the therapist might say, 'You seem hesitant and I think irritated, although I am not sure what the focus of your irritation is.' If the contact has a feeling of relational depth or 'presence' despite the difficulties experienced, the therapist might say nothing, letting her own presence simply touch the presence of the client … or may say something like 'There's an edge between us; I don't understand what's happening. Being empathic was so easy but it's not now.'

The focus is the changing quality of psychological contact. The centrality of being congruent, empathic and unconditional is already known; what is new is acknowledging and making *explicit* this shifting qualitative sense of relationship as psychological contact.

Cameron notes: 'We are not all indiscriminately available for psychological contact' (2003, p. 88). We place limits and conditions on both our availability and our receptivity to the other. She discusses how we extend, contract and block psychological contact towards one another in relation to:

- cultural norms of what is socially appropriate within a specific culture;
- our own needs and mood;
- who the other person is and how they behave;
- our response to them; for example, if we feel apprehensive or irritated, we may block, withdraw and contract rather than feel interested and caring and then extend and open towards the client.

The client can 'turn towards' (or 'away from') the therapist, and the therapist can 'turn towards' (or 'away from') the client. Davies and Aykroyd point out that we are more aware of psychological contact when there is an impediment as the flow of experiencing between therapist and client 'informs our felt sense of the quality of the meeting' (p. 221).

Davies and Aykroyd (2002) highlight the problems of making psychological contact across a cultural divide and assert that people in oppressed minorities are sensitive to others who demonstrate their non-availability for contact. Therapists may be aware of how homophobia, racism, nationalism, sexism and ageism are blocks to empathy, but may not have considered how (possibly out of awareness) they might affect availability for contact with another.

Cameron (2002) elucidates the role of language in this process – 'information is encoded by using language in a way that indicates our ethnicity, class, religion, politics etc' (p. 95) – and highlights that shared meanings cannot be assumed. The therapist needs to develop cultural sensitivity to recognize the different perceptions, values and beliefs underlying their own and their clients' meanings, which are encoded in language. The therapist will then be available and able to receive the client's encoded messages and communicate their availability, their receptivity and their understanding of the encoded messages. As Cameron says, 'What matters is whether the meaning we intend matches the meaning that is taken' (p. 97). Supervision, additional training, dialogue with colleagues and personal therapy may all help the therapist in these areas, but perhaps living a multidimensional cultural life will have the deepest impact.

Psychological contact in holistic/emergent relationships

Ellingham (2002), Schmid (2002), O'Hara (personal communication, 2006) and my own explorations (Wyatt, 2004) accentuate the holistic/emergent nature of psychological contact. Here the relationality discussed in 'ordinary' person-centred relationships is extended. Our person-centred practice now changes and evolves to account for the interpenetrative fields of the influence of self, others, culture and the organic world, for instance the phases of the moon, the Tsunami, the 'fight against terrorism' or the weight of patriarchy through the ages.

Encounter (Schmid, 1998, 2002) and relational depth (Mearns & Cooper, 2005) could be considered to be aspects of this holistic/emergent view of psychological contact. Therapist and client participate in the relationship and the degree of their availability and receptivity to each other influence the quality of psychological contact and the 'encounter' that emerges. The other, with all of their cultural and personal differences, is acknowledged as a person having an 'open future' (Schmid, 2002, p. 193). This means dropping all the assumptions, expectations and aims we may have for the client.

The therapist is available and receptive to contact with another, and this openness creates the possibility of being changed by the encounter. A 'special dance' is required by the therapist: a slowness to allow the client's story to unfold, a sensitive accepting empathy or 'holistic listening' (Mearns & Cooper, 2005), a spontaneity and authenticity, a willingness to 'not-know' and be vulnerable, and perhaps most importantly a capacity for the client to matter and to affect the therapist. Sometimes

this 'relational depth' will arise from very sensitive empathic responding, sometimes by silence and sometimes by being 'interactive, bi-directional and mutual' as described by Mearns and Cooper (2005, p. 9).

At times, an 'extra dimension' is accessed and a 'non-cognitive' intelligence is realized. Rogers described this as a knowing that is 'wiser than the intellect' (Rogers, 1963, p. 18), 'something around the edges of these conditions that is really the most important element of therapy' (Baldwin, 1987, p. 45). The quality of this psychological contact might be described as 'electric', 'intense', 'vital', 'oneness', 'transformative'. This is the 'presence' that Rogers wrote about (Rogers, 1980), and at these times all of Rogers' conditions are simultaneously present. Perhaps this extra dimension emerges from the wider web of influence.

The therapist also has awareness of the interpenetrative influences and how they may impinge on the therapeutic relationship. These might include: the increasingly frenetic pace of life; increasing ecological pressures such as climate change, pollution and decreasing biodiversity; the bombings in London; and bombardment by the media. The emphasis still remains with the client, but there is also an availability and receptiveness to these interpenetrative influences. The therapist is congruent with this wider web of influence and extends her empathy and UPR to this wider field. The encounter thus occurs within this wider field. This shifts the balance from an individualistically focused psychotherapy to a holistic psychotherapy in which the individual is both a whole and a part of a society. Psychotherapy, in this way, can function as sociotherapy (Schmid, 2001) and eco-therapy (Roszak, Gomes, & Kanner, 1995).

Conclusion

Each conceptualization of psychological contact examined here has, I believe, relevance for our practice. The implication is for therapists to develop the ability to sense and move their way of contacting and relating in response to their client, the evolving therapeutic relationship, the cultural context and the wider web of influence. This could be seen as an extension of Margaret Warner's 'process-sensitive' therapy (see Chapter 23). With disturbed clients in pre-expressive or fragile process, Pre-Therapy's contact reflections may help, as may sensitive empathic responses. For clients in grey-zone functioning, the therapist will responsively shift from contact reflections to empathic understanding as the client moves from pre-expressive to 'expressive'. Many clients will respond to the contact characterized by a congruent, acceptant, empathic understanding of person-centred therapy, while other clients will draw a more 'interactive, bi-directional and mutual' encounter. The client as global citizen calls for an extended contact, which acknowledges mutual causality, intersubjectivity and the interpenetrative fields of influence of an interconnected universe.

Points for reflection

- What is your worldview and how does it influence your understanding of contact?
- In your sessions with clients, see if you are aware of the changing quality of the contact between you and your client. What might be creating these fluctuations?
- How might the economic, political, societal and ecological context be significant in your client work?

Key readings

- Bohm, D., & Peat, D. (2000). *Science, order and creativity*. London: Routledge.

A book that addresses how the evolution of knowledge and thus science defines reality, and how these orders from different evolutionary times coexist. It helps to contextualize the significance of worldviews and culture through which we make contact and relate to each other.

- Roszak, T., Gomes, M., & Kanner, A. (Eds.) (1995). *Ecopsychology*. San Francisco, CA: Sierra Club Books.

An old favourite that extends individual psychology out into nature and ecology, and begins to address wider cultural implications.

- Wyatt, G., & Sanders, P. (Eds.) (2002). *Rogers' therapeutic conditions: Evolution, theory and practice*. Vol. 4. *Contact and perception*. Ross-on-Wye: PCCS Books.

The first book to attend to Rogers' 'forgotten conditions', this provides a wealth of information across the 'tribes of the person-centred approach' in relation to contact and perception.

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Note

Thanks go to Pete Sanders and Lisbeth Sommerbeck for their contribution to an earlier version of Chapter 10.

11
Empathy

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This chapter discusses:

- The definition of empathy
- The theoretical underpinnings of empathy
- Communicating empathy
- The empathic acceptance process
- Empathy across the diverse person-centred orientations
- Empathy on working with psychotic or difficult processes
- Research findings on empathy
- Reflections for the future

Definition of empathy in person-centred therapy

The word 'empathy' was first introduced by Rogers in 1951, in his book *Client-centered Therapy*, when he described the role of the client-centred therapist as that of assuming the client's internal frame of reference and trying to understand them from that standpoint. Empathy was defined then as a particular type of understanding, clearly distinct from the types of understanding that come from external frames of reference, such as psychodiagnosis:

> It is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client. (Rogers, 1951, p. 29)

Rogers (1951) considered the role of the therapist to be to put her self aside – 'the self of ordinary interaction' – and to enter into the perceptual world of the client as completely as she is capable of, becoming, in a sense, an *alter ego* of the client's feelings and attitudes. This would provide a safe opportunity for the client to experience himself more truly and deeply, to discern himself more clearly and to choose more significantly (p. 35).

Later, in 1980, Rogers presented a more refined and complex definition of empathy, in which it became a *process* and a *way of being* rather than a fixed state. Thus, empathy was defined as a holistic experience of the therapist encompassing several facets:

> It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing. It means temporarily living in the other's life, moving about in it delicately without making judgements; it means sensing meanings of which he or she is scarcely aware, but not trying to uncover totally unconscious feelings, since this would be too threatening. It includes communicating your sensings of the person's world as you look with fresh and unfrightened eyes at elements of which he or she is fearful. It means frequently checking with the person as to the accuracy of your sensings, and being guided by the responses you receive. You are a confident companion to the person in his or her inner world. By pointing to the possible meanings in the flow of another person's experiencing, you help the other to focus on this useful type of referent, to experience the meanings more fully, and to move forward in the experiencing. To be with another in this way means that for the time being, you lay aside your own views and values in order to enter another's world without prejudice. In some sense it means that you lay aside your self; this can only be done by persons who are secure enough in themselves that they know they will not get lost in what may turn out to be the strange or bizarre world of the other, and that they can comfortably return to their own world when they wish. (Rogers, 1980, pp. 142–3)

Theoretical underpinnings of empathy in person-centred therapy

Rogers discovered, in his very early years as a therapist, that a therapeutic relationship is more effective the more completely the therapist tries to understand the client *as the client seems to herself* (Rogers, 1946). In the field of psychotherapy, where diagnostic knowledge is considered essential for effective therapy, this statement sounds like a heresy as much today as it sounded in the 1940s. In fact, Rogers provoked a revolutionary impact on the field of psychotherapy by requiring the therapist to 'lay aside his preoccupation with diagnosis and his diagnostic shrewdness' and to concentrate on providing an empathic understanding of the client's frame of reference. In

proposition VII of his 1951 theory of personality, Rogers stated that 'the best vantage point for understanding behavior is from the internal frame of reference of the individual himself' (p. 494), thus asserting the superiority of empathy over diagnosis in understanding individual's behaviour. Later, in his 1959 theoretical formulation (Rogers, 1959), empathy became one of the six necessary and sufficient conditions of therapeutic personality change (see Chapter 2).

In person-centred theory, empathy is a concept deeply intertwined with the concept of the 'actualizing tendency'. The therapist's aim of entering the client's internal frame of reference and the therapist's reliance on this empathic understanding to achieve therapeutic outcome is, according to Rogers (1951), 'the most complete implementation' of the 'central hypothesis of respect for and reliance upon the capacity of the person' (pp. 35–6). In other words, it is the therapist's reliance on and trust in the client's actualizing tendency that ultimately underpins and sustains their empathic attitude in the therapeutic relationship.

Rogers (1986) considered empathy to be a healing agent in itself and one of the most potent aspects of therapy. Empathy dissolves alienation: 'it releases, it confirms, it brings even the most frightened client into the human race. If a person is understood, he or she belongs' (p. 129). Moreover, empathy leads to 'self-empathy' (Barrett-Lennard, 1997). Being listened to by someone who understands makes it possible for the person to listen more accurately to herself, with greater empathy toward her own visceral experiencing (Rogers, 1980). When the client sees her own attitudes, feelings and perceptions accurately expressed by the therapist, she can accept into her self all these elements, now more clearly perceived. Because the therapist has been able to adopt her frame of reference, and to perceive with her, with acceptance and respect, the client can own and assimilate these experiences into a now altered self-concept. And 'once the self-concept changes, behaviour changes to match the freely perceived self' (Rogers, 1980, p. 155).

Communicating empathy in the therapeutic relationship

Reflection of feelings

The typical way by which the client-centred therapist communicates empathic understanding was initially described as a 'reflection of feelings' (Rogers, 2002, p. 13). That is because when the therapist tries to understand the client empathically, laying aside her own judgements and values *in order to grasp, with delicate accuracy, the exact meaning the client is experiencing*, the therapist's responses would serve as a mirror. From the client's point of view, the therapist would be perceived as holding up a 'magical mirror' (Slack, 1985), reflecting a clear image of the meanings and perceptions as experienced by him, which would be clarifying and insight-producing.

However, the term *reflection of feelings* has often been misunderstood and trivialized, and has become a caricature of person-centred therapy. Nowadays, empathy is commonly misconceived and misportrayed as a set of techniques called 'reflective

listening' or 'active listening', encompassing mechanistic ways of responding such as 'paraphrasing' and 'summarizing'. In this misconception of Rogerian empathy, the intersubjective experience of empathy is reduced to a mere response technique (Bohart & Greenberg, 1997; Bozarth, 1998). Unfortunately, this misrepresentation of empathy has become widespread across all levels of psychotherapy training and textbooks, from introductory counselling skills courses to professional doctorate degrees.

Rogers (2002) himself was concerned with the use of 'reflection of feelings' as a 'wooden technique' (p. 13). However, Shlien (cited by Rogers, 2002) pointed out that the term 'reflection of feelings' was unfairly damned since 'it is an instrument of artistic virtuosity in the hands of a sincere, intelligent, empathic listener. It made possible the development of person-centred therapy, when the philosophy alone could not have' (p. 13).

Empathic understanding response process

Given the common misunderstanding of Rogerian empathy as a mechanistic and narrow technique, Brodley proposed a change in the name 'reflection of feelings' to *empathic understanding response process* (EURP) (Temaner, 1977). Brodley (2001) stressed that the EURP is not a technique, but rather a process and an attitude. It is a close following of the client, in which the therapist is not only focused on the client's feelings or the client's literal words, but instead 'is trying to grasp the meanings that the client seems to intend to be understood by the listener' (p. 17). Also, in the EURP, all the therapist's responses are inherently tentative, as if the therapist were asking the client: 'Is this accurate?' Hence, the EURP enables the therapist to correct misunderstanding and to access deeper levels of meaning. Later, Brodley (2001) renamed this process '*acceptant* empathic understanding', emphasizing that the primary intention of the therapist it to continuously experience an acceptant, empathic attitude in relation to the client. Brodley emphasized that the therapist's sole goal is 'to understand the client in a manner that is likely to result in the client's having the experience of being understood' (pp. 17–18).

Empathic attunement

Another way of describing the empathic understanding process is by an analogy with the experience of musical attunement, in which a singer matches their pitch with the melody of another singer. Using this metaphor, listening to the client empathically would mean *attuning* to the client's experiences in the here-and-now or – extending the metaphor a little – attuning with the *melody* (or tune) of the client's soul (or client's organism, to use a more scientific word). That is, through the empathic attunement, the therapist vibrates or resonates with the client's melody that is emanating from their *soul* (or organism) in the immediacy of the therapeutic encounter.

When the client is distressed, desperate, frightened, overwhelmed, confused or in a state of incongruency, they may not be able to hear themselves fully. The client

may hear only the loud voices of their *conditions of worth* (see Chapter 8), and the melody of their souls might be just subceived or barely heard as they have been relegated to the edge of their awareness by their defensive processes. However, through the empathic attunement, the therapist can hear and resonate with this quiet, stifled and neglected melody.

Another way of describing this experience is by saying that, through the empathic attunement, the therapist can listen to and understand the core meaning that is being expressed beyond the words, or between the lines, of the client's verbal communication. When the therapist communicates this core meaning back to the client through their empathic understanding responses, they help the client to listen to themselves more fully and to integrate those parts of their organismic experience that have been alienated and relegated to the fringe of their consciousness. For the client, the experience of being heard in this way is powerful and unique. The resulting acceptance of the totality of their organismic experience in a renewed sense of self is the key therapeutic change in the process of person-centred therapy. Boxes 11.1 and 11.2 show examples of this empathic understanding process.

Box 11.1

Examples of empathic understanding responses

Below are excerpts of a session with a young female client (C), who is exploring her difficulties ending an emotionally abusive relationship. These excerpts were transcribed from an audio-recorded session, but the transcripts have been slightly adapted in order to help the understanding of the example and to protect client's anonymity.

C: I saw him again last week, and it just brought a lot of things back, and I just feel I need to let go of that and move on and I find it very difficult …

T: It feels hard for you to let it go …

C: Yep, it does. But I don't know what else I can do. I just need to go with it, but it's very difficult because I know that when he comes back, he'll come and see me, and that's going to be difficult again … because I'll be really happy to see him, but it's just not worth it …

T: Although you do want to move on, you know that when you see him in front of you … you will just feel happy to see him …

C: Uhuh, but then I just get hurt though, and then it's not worth it. And I need to move on, I feel I need to, but I'm not and I don't know what else to do.

T: It's like a part of you says 'you need to stop that, you must not open the door any more', but there's a part of you who resists that and wants to let him in …

The therapist tries to reach out to the whole experience of the client and to communicate an understanding of both parts of the client's experience: the part that wants to see her boyfriend and the part that wants to stop seeing him.

C: Yeah, cos I want to see him, and I'm happy to see him and I want to be with him. But he's no good for me, and that's the problem … If I didn't feel anything it would be fine …

…

C: Like I feel I'd like to be with him, but I don't know why. Why I would want to be with someone like that?

T: You don't know what he gives to you …

The therapist does not try to rescue the client by offering an answer to her question. Instead the therapist stays empathically attuned with the client's experience of not knowing and being distressed by that. Moreover, the therapist does not stay on the surface of the content of the question 'why I want to be with someone like that' but tries instead to reach out to the core meaning of the client's experience, which seems to be the feeling that there is something that he is giving to her.

C: I think it's just because, because we've been intimate and I just get attached then. I can't switch off, so that probably is why [*voice trembles*] …

T: Because of the deep intimacy … that's the thing you don't want to let go, these moments of intimacy that you like so much …

C: Yeah.

T: You don't want to miss that …

C: No [*cries*] … yeah, I think that's just what it is with me …

Through the empathic acceptance process, the therapist helped the client to connect with a part of her experience of which she had not been fully aware. Then, she was able to realize and understand that it was the moments of deep intimacy that were attaching her to this otherwise deeply hurting relationship. It is worth noting that it was the client herself who found the answer to the question 'why do I want to be with someone like that?' She found in herself the answer that it was because of the moments of intimacy she experienced with him. The therapist has just facilitated the process by which this response emerged out to the client's awareness.

…

C: It's like when I'm with him, I feel like a kid. I feel like … you know … when you're a kid and you've got your best friend and you just like to be with each other and just be a kid … it feels like that …

T: Like you're being a kid again …

C: Yeah, for a few minutes or whatever …

T: Kind of pure joy?

C: Yeah [*cries*] …

The therapist's response goes beyond the client's words ('feeling like a kid') and tries to resonate with the core meaning that client was trying to communicate with these words. In her empathic attunement, the therapist understood that the experience the client was trying to communicate was 'pure joy' and offered this empathic understanding to the client. She cries then as the therapist's response helped her to connect even more with the core of her experience.

Box 11.2

The use of images or metaphors to communicate empathic understanding

When the therapist is deeply immersed and absorbed in the empathic attunement process, an image can sometimes appear in her mind that portrays the experiences and feelings of the client in a holistic and penetrating way that words alone could not do. The example below is an excerpt retrieved from the same session described in Box 11.1.

C: It's because I have feelings for him that I've kept it going, like I want to see him if he comes to my door, or I will reply if he emails … it's because I've got feelings for him, because I want to see him …

T: Listening to you now … this image came to me … of a pearl in a pile of manure …

C: Uhuh, that's exactly it!

T: So, there is a pearl there, and you just want the pearl … That's really what you want, but there's all this mess …

C: Yeah …

T: … that comes with it …

C: Mhuh, so it's that what I get from him I guess … I'm not getting it from … I've not met anyone else to be as close to …

T: Other people you've met just don't give you that precious thing …

C: Nope.

T: So you come back to your pearl in the middle of the …

C: Yeah, I'll put up with all that to feel close to him …

T: Because these moments of closeness …

C: Mhuh

T: … feel so precious to you …

C: [*cries*] Yeah, I'd rather not feel it all, I'd rather have never felt it …

The empathic acceptance process

Many contemporary authors (see, for example, Bozarth, 1998; Freire, 2000; Mearns & Cooper, 2005; Wyatt, 2001) have considered that although the Rogerian core conditions of empathy, unconditional positive regard and congruence are taught as separate variables, their interrelationship is so high that they are ultimately and functionally one sole condition, which Mearns named *genuine empathic acceptance* (see Mearns & Cooper, 2005, p. 17). Indeed, Rogers (1980) indicated that empathy and unconditional positive regard are in fact inseparable when he affirmed that 'true empathy is always free of any evaluative or diagnostic quality' and that the 'highest expression of empathy is accepting and nonjudgemental' (pp. 151–5).

Therefore, because of the non-evaluative and acceptant quality that Rogers ascribed to empathy, Bozarth (2001) pointed out that it would be more accurate to identify Rogerian empathy as *unconditional empathic reception* (p. 152). Moreover, Bozarth considered that empathy in client-centred therapy is a manifestation and the purest way of communicating unconditional positive regard. He concluded that 'Rogerian empathy' is so intertwined with unconditional positive regard that empathic and unconditional acceptance are, in essence, the same experience. In relation to congruence, Bozarth (1998) asserts that there is no empathy without congruence since it is the therapist's congruence that affords the therapist the capacity to experience empathy towards the client.

Components of the empathic acceptance process

The therapist's verbal communication of their empathic understanding to the client is simply the last stage of a much larger *genuine empathic acceptance* process. Before

the therapist can verbalize any true empathic response, a subtle but profound process must already have been initiated in the therapeutic encounter. The therapist's verbal responses are like the small tip of the immense iceberg of the empathic process that lies invisible below the surface of the therapeutic encounter. This process might be understood as comprising a number of components, verbal responses being just one of them. These components are artificially presented here as distinct dimensions of the empathic process, but in fact they constitute a sole and unified process that unfolds in the immediacy of the encounter:

- *Valuing the Otherness of the client.* The therapist receives the client with a profound sense of prizing and valuing of their Otherness. The therapist holds a sense of awe towards this other human being in front of them, whoever this person is and whatever the problem or circumstances they bring. This may be a sense of mystical or spiritual reverence.
- *Clearing the mind.* The therapist holds an attitude of empty mindfulness, like a Zen-Buddhist meditational stance. The therapist clears space in their mind; they quiet or silence their internal 'noise' so that they can listen to the client's *melody* in the here-and-now.
- *Receiving unconditionally.* The therapist receives the client with complete openness to the unexpected and to the unknown. The therapist holds no attachment to and no expectation of the results of the therapeutic encounter.
- *Reaching out/tuning in.* After clearing their mind and receiving the client unconditionally, the therapist is now able to resonate with, to attune to, the client's inner experience. The therapist is now able to reach out to the client's internal world and to understand the client's frame of reference.
- *Communicating understanding.* Finally, the therapist offers the client their empathic understanding of the experience the client is trying to communicate. The therapist offers that understanding tentatively, in a gentle and caring way. The therapist has no certainty, and their verbal responses are offered without demands of acceptance and recognition. The empathic understanding responses are given to the client as humble offers, which the client may or may not take in.

Box 11.3 shows the common shortfalls of therapists in this empathic acceptance process.

Box 11.3

Common shortfalls of therapists in the EURP

There are many ways on which a therapist can fall short of responding empathically to the client's experiences. Some of the most commons shortfalls of the therapist's empathy are listed below:

- responding only to the surface content of the client's communication, getting distracted by the details of the client's narrative;

- staying in the 'head', that is, responding intellectually, without attunement to the underlying feelings and meanings;
- listening only to the 'noise' emitted by the client's defences and conditions of worth, instead of listening to the core meaning, or *melody of the soul*;
- minimizing clients' experiences and not acknowledging or addressing their painful or intense feelings;
- trying to 'rescue' the client (for example, offering answers when the client is confused, comforting, reassuring or moving the client away from painful or difficult processes);
- holding expectations for the therapeutic process;
- conveying conditional regard (for example, criticism or appraisal of client's experience, either subtle or overt).

Empathy across the diverse person-centred orientations

Person-centred therapy is nowadays one 'nation' with many distinct 'tribes', reflecting distinct understandings of person-centred theory and distinct ways of applying it to practice (see Chapter 4). Although the focus on the phenomenological world of the client is a common ground for all person-centred orientations, there are differences among them in relation to *how* the therapist should communicate empathy.

In the *classical* perspective, the therapist's empathic responses are not intended to deepen the client's experiential focus, although this is a frequent consequence of the empathic acceptance process and often plays a role in therapeutic change (Brodley, 1990; Prouty, 1999). According to this perspective, when the therapist is striving to experience empathy towards the client, she absorbs herself completely in trying to get *within*, and 'in struggling to do this, there is simply no room' for any other type of activity or attitude. The therapist cannot be diagnosing the client, 'cannot be thinking of making the process go faster' (Raskin, cited by Rogers, 1951, p. 29).

In the *focusing* and *process-directive* orientations, on the other hand, empathic responses are intended not only to convey understanding, but also to promote an exploration of the client's experience. According to the process-experiential perspective, there are five forms of empathic response: *understanding, evocation, exploration, conjecture* and *interpretation* (Greenberg & Elliott, 1997). These forms vary according to whose frame of reference is being used in making the response – on a continuum from the client's frame of reference, through a shared frame of reference to the therapist's frame of reference – and according to the degree of new information that is added – from reflective empathic understanding, where 'no new information is added', to empathic interpretation, where the highest degree of information is added (p. 175).

Lietaer (2001) pointed out that the new branches that have grown out of the person-centred approach over the past 30 years have moved away from the original Rogerian conceptualization of the therapist's role as putting her self aside and becoming an 'alter ego' for the client. These new orientations of the person-centred approach are characterized by the therapist's freer use of self, with more use of self-disclosure by the therapist. This perspective has been further explored within the model of 'working at relational depth' developed by Mearns and Cooper (2005).

Empathy on working with psychotic or difficult processes

Warner (2001) emphasized the importance of the empathic acceptance process when working with clients engaged with difficult processes (that is, fragile process, dissociated process or psychotic process – see Chapter 23). She pointed out that it is paramount for the therapist to keep their frame of reference aside and to stay quite close to the client's exact words and expressions when clients are in a 'difficult process', since 'even small increases in the complexity of the therapist's response can leave clients feeling violated and confused, and make it difficult for them to stay connected to their experience' (p. 187). Warner asserted that clients can, at such times, easily be 'thrown off' by therapist communications that are too distant from the immediacy of their experience, such as paraphrasing, questions or comments. She found that the most helpful thing a therapist can do is 'to just stay present and maintain very close empathic connection' (p. 186). When this happens, emotions shift and release, and clients return to contact with reality.

The method of *empathic contact*, developed by Prouty (2001) in his theory of 'Pre-Therapy' (Prouty, Van Werde, & Pörtner, 2001; see also Chapter 22) is an expansion of the empathic method with the aim of reaching out to clients who are 'contact-impaired', that is, who are psychologically withdrawn, are isolated and present autistic features. Prouty says that, when working with contact-impaired clients, therapists are handicapped empathically because their own limits in terms of 'resonating' with psychotic experience curtail their ability to 'feel into' them. Empathic contact is thus a literal and concrete form of empathic response, which allows the therapist to relate to the regressed aspects of psychosis or psychotic-like states.

Research findings on empathy

The therapeutic effects of empathy are supported by the evidence accumulated in psychotherapy research, which strongly suggests a positive association between empathy and therapeutic outcome (see, for example, Bohart, Elliott, Greenberg, & Watson, 2002; Orlinsky, Grawe, & Parks, 1994; Stubbs & Bozarth, 1994). A meta-analysis of the effectiveness of empathy has been conducted by Elliott, Bohart, Watson and Greenberg (2010) as part of the Task Force on Evidence-Based Therapy Relationships jointly sponsored by the American Psychological Associa-

tion's Division of Psychotherapy and Division of Clinical Psychology. The goal of this task force was to identify and disseminate what works in the therapy relationship (Norcross, 2010).

Elliot et al. (2010) analysed 57 studies (involving a total of 3,599 clients) that used a measure of therapist empathy and found that empathy 'predicted treatment outcome consistently across different theoretical orientations (for example, cognitive-behavioural, humanistic), treatment formats (individual, group) and levels of client problem severity' (p. 13). The overall effect size between therapist empathy and successful outcome was estimated as $r = 0.30$, which is considered to be a medium effect. According to Norcross and Lambert (2010), this result means that clients with empathic therapists 'tend to progress more in treatment and experience a higher probability of eventual improvement' (p. 2).

Conclusion: thoughts for the future

The person-centred approach has been a revolutionary paradigm in the field of psychotherapy and helping relationships since its origins in the 1940s. When Rogers replaced diagnosis with empathic understanding, he drastically reversed the power dynamics in the client–therapist relationship. Through empathy, the expert in the therapeutic relationship became the client and no longer the therapist. When therapists rely on the client's frame of reference as the 'best vantage point for understanding' the client, they depart radically from the medical paradigm and its model of power and control over the individual (see, for example, Proctor, 2005). This revolutionary aspect of empathy in psychotherapy has been difficult for other approaches to assimilate.

Nowadays, most (if not all) approaches in psychotherapy acknowledge the pivotal importance of empathy in the therapeutic relationship. Bozarth (1998), however, asserts that Rogerian empathy is different from all other concepts of empathy: 'the actualizing tendency as the foundation block for the [person-centred] approach creates a context that places Rogerian empathy in a different frame than empathy in other theoretical orientations' (p. 146). In person-centred therapy, the therapist does not intend any specific outcome from being empathic, but instead to communicate unconditional positive regard, whereas in other therapeutic approaches empathy is viewed as a means either to gather data for later interpretation or to bond the therapeutic alliance in order to prepare the client for receiving the therapist's other interventions.

Notwithstanding these differences, it is important to promote dialogues between the person-centred community and other psychotherapeutic orientations in order to unfold new perspectives on empathy. In particular, the developmental and intersubjective perspectives (Jordan, 1991) can illuminate the relationship between empathy and the experience of 'we-ness', the transcendence of the separate and disconnected self.

Points for reflection

- What do you think is the difference between empathy, identification and interpretation?
- How do you understand the relationship between empathy and congruence? How do you explain Bozarth's assertion that it is the therapist's congruence that affords the therapist the capacity to experience empathy towards the client?
- To what extent do you think empathy can be taught? Do you think some people are naturally more empathic than others?
- Do you think that quantitative and positivist research can provide valid and meaningful knowledge about the role of empathy in therapy? Why?

Key readings

It is always very helpful to go back to the original sources to obtain a more accurate and complete understanding of a particular subject. In the case of empathy, reading Rogers' original writings is obviously highly recommended. Among the many books and articles written by Rogers, we would recommend particularly the following chapters as core texts on the subject of empathy:

- Rogers, C. R. (1951). *Client-centred therapy: Its current practice, implications and theory*. London: Constable. Chapter 2: The attitude and orientation of the counsellor.

Rogers explains and explores in detail how to implement the empathic attitude in the therapeutic relationship. This is considered by many scholars and practitioners to be the best writing by Rogers on the topic of implementing the client-centred attitude.

- Rogers, C. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin. Chapter 7: Empathic: An unappreciated way of being.

The most in-depth and comprehensive writing on empathy by Rogers, in very accessible language.

Other recommendations are:

- Bohart, A., & Greenberg, L. S. (Eds.). (1997). *Empathy reconsidered: New directions in psychotherapy*. Washington, DC: American Psychological Association.

A comprehensive overview of the different roles that empathy plays in other theoretical perspectives, for example psychodynamic, feminist, relational and cognitive.

- Brodley, B. T. (2011). *Practicing client-centered therapy*. Ross-on-Wye: PCCS Books.

Selected writings of Barbara T. Brodley. The section 'Implementation of the values and attitudes in an expressive client-centred therapy' is particularly helpful for understanding the practice of the EURP.

■ Tolan, J. (2003). *Skills in person-centred counselling and psychotherapy*. London: Sage.

An introduction to the skills of person-centred therapy. The language of the book is very accessible, with helpful exercises and examples from practice.

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12

Unconditional positive regard

JEROLD D. BOZARTH

This chapter discusses:

- The core concepts and history of unconditional positive regard (UPR) in Rogers' theory
- The divergence of views in 'person-centred theories'
- The research on UPR
- The variable translations of the concept of UPR
- Critical reflections for the future of the construct of UPR

A major tenet of Carl Rogers' theory of therapy is that individuals have a *need for positive regard* (Rogers, 1959; Box 12.1). It is the *congruent* therapist's experiencing of *unconditional positive regard* (UPR) towards the client along with *empathic understanding* of the client's internal frame of reference that precipitates therapeutic personality change when it is perceived by the client.

Box 12.1

Positive regard and UPR

UPR is 'warm acceptance of each aspect of the client's experience'. Positive regard occurs when the client perceives that he or she is making a positive difference in the experiential field of the therapist. (Rogers, 1959, p. 209)

The core concepts

An examination of UPR must be considered within the context of the 'conditions of the therapeutic process' (Rogers, 1959), also referred to as the 'necessary and sufficient conditions' (1957). These conditions guide therapeutic practice in Rogers' theory of therapy (see Chapter 2 for more on the conditions).

History

The therapist's attitude of acceptance and respect (Rogers, 1951) was the forerunner of UPR (Rogers, 1959). The inclusion and operational definitions of the concepts of *positive regard* and UPR clarified and concretized the theory (Bozarth, 2001a).

In his book *Client-centered Therapy*, Rogers (1951) set forth the attitude and orientation of the client-centred therapist. He also set forth a theory of personality and behaviour that included his 19 propositions. In 1951, the premise for UPR was set as the therapist's perception of the 'client's self as the client has known it, and accepts it', with the caveat that 'the therapist accepts the contradictory aspects as part of the client with the same warmth and respect' (p. 41). Hence, the client is 'enabled to do this [integrate his self-concept] … because another person has been able to adopt his frame of reference, to perceive with him, yet to perceive with acceptance and respect' (p. 41). Acceptance and respect evolves to become UPR in 1959. Rogers' theory of personality describes the central role of UPR in the section on 'The process of reintegration' (Rogers, 1959). There *must* be a decrease in the conditions of worth and there *must* be an increase in unconditional self-regard in order for reintegration to be possible. Communicated UPR is 'one way of achieving these conditions' (p. 230).

Client-centred theory was, however, evolving even as the 1951 book was published. Standal (1954) was at that point working on and completed his dissertation focusing on positive regard and UPR. Rogers (1959) delineated the core of Standal's postulates in the 1959 theory, and adopted Standal's term 'unconditional positive regard'. The need for positive regard was considered as a basic *learned* secondary need of individuals, usually developed in infancy.

Prior to Standal's dissertation, Oliver Bown contended that 'love' was what the therapist offered and received from clients. Bown argued that love was communicated 'primarily at subverbal, subliminal or subconscious levels' (Rogers, 1951, p. 161). Bown's belief about the communication of 'love' is referred to in the theory in the earlier theory statement (Rogers, 1951, p. 160) but became less obvious than Standal's constructs, which were more explicitly incorporated into client-centred theory.

UPR became an identified and integral part of client-centred therapy in Rogers' (1959) self-proclaimed magnum opus. Rogers considered the term to be more precise than such terms as 'love' and 'affection' used by others who proposed such needs as inherent infantile traits (Rogers, 1959). The need for positive regard became central to the theory. Rogers adopted Standal's literal definition of positive regard:

> If the perception by me of some self-experience in another makes a positive difference in my experiential field, then I am experiencing positive regard for that individual. In general, positive regard is defined as including such attitudes as warmth, liking, respect, sympathy, and acceptance. To perceive oneself as receiving positive regard is to experience oneself as making a difference in the experiential field of another. (Rogers, 1959, p. 206)

Thus, one major assumption in the theory of 'client-centred therapy' (classical person-centred therapy) was established – the individual need for positive regard. UPR is defined more generally as 'a warm acceptance of each aspect of the client's experience' (Rogers, 1959, p. 209). *Theoretically, UPR occurs when the client perceives that she is making a consistent positive difference in the experiential field of the therapist*.

The theory statement

The explanation of 'pathology' in Rogers' theory is that the client becomes *incongruent*, being *vulnerable* or *anxious* due to experiencing 'conditions of worth' on the part of significant others. The individual's conditions of worth then develop into conditional positive self-regard. It is when conditional positive regard conflicts with the individual's organismic experiences that the person becomes *incongruent*. The corrective factor with the development of conditional positive regard is that the client perceives the therapist's UPR. It is the client's perception of the therapist's UPR offered through empathic understanding that facilitates the client's unconditional positive self-regard.

UPR is the factor that frees the client from 'conditions of worth' (Rogers, 1959, p. 224). It is the facilitation of freedom from these conditions that incorporates organismic experiences into the self-structure. The client's congruence of self with her organismic experiences is subsequently aligned with the *actualizing tendency*.

Divergence of views

There are differing views of UPR among advocates of person-centred therapies. These views are reflected, on one hand, by assertions that UPR is the 'curative' factor in person-centred therapy (Bozarth, 2001a) and 'the distinct feature of Client-Centred Therapy' (Freire, 2001, p. 145). On the other hand, UPR has also been argued to be a 'crucial' but impossible task for the therapist (Lietaer, 1984, 2001).

The 'classical' view is Rogers' theory (Rogers, 1959). The other (post-classical) person-centred therapies adhere to focused activity of the therapist in addition to valuing the conditions espoused by Rogers. This group offers different theoretical thrusts and places less importance on UPR as constructed in the theory. These person-centred therapies include focusing-experiential therapy (Gendlin, 1974; Hendricks, 2001; Iberg, 2001) or focusing-oriented therapy (Purton, 2004), eclectic/experiential therapy (Lietaer, 2001), process-experiential therapy (Elliott & Greenberg, 2002), more recently identified as 'emotion-focused therapy' (Pos &

Greenberg, 2008), and clarification-oriented psychotherapy (Sachse, 2004; see also Chapters 4 and 17).

The integrative and existential positions have more complex relationships to Rogers' theory. Existential theory consists of a 'diverse range of independent-yet-interrelated existential therapies that vary enormously in their similarity to a classical client-centred practice' (Cooper, 2004, p. 95). Integrative 'theory' is also varied, with the invitation to others to develop 'what it is to be themselves as person-centred practitioners' (Worsley, 2004, p. 125).

Bozarth (1998, 2001a), a representative of the classical view, argues that UPR is the 'the curative variable', asserting that it can be no other way since Rogers' 'theory of pathology' points to 'conditional positive regard' as the condition that creates the client's incongruence. UPR communicated through *empathic understanding* is in and of itself the curative factor that frees the client to integrate with the experiences of the organism. Thus, organismic and self-experiences ultimately become integrally aligned with the unitary actualizing tendency (Rogers, 1963). Bozarth (2001a) proposes that this *is* Rogers' (1959) theory and that to ignore this underlying assumption results in a radical change of Rogers' theory of therapy.

Bozarth (1998) proposes a reconceptualization of the therapist conditions. This conceptualization has been further developed by Bozarth and Wang (2008), in which they propose that 'unconditional positive regard and empathic understanding are process constructs integrally related to the actualizing tendency' (p. 112). They further conclude that these 'two attitudes to be experienced by the therapist, … are part of and also emergent from the congruent therapist' (p. 112).

Freire (2001) captures the theoretical nature of UPR in relation to the foundation block of the classical view when she states: 'The greater the extent the therapist trusts the client's actualizing tendency, the greater her capacity to experience unconditional positive regard towards the client' (p. 147).

The primary difference between Rogers' (1959) theory of therapy and other person-centred therapies (classical or post-classical) is that most of the post-classical person-centred therapies do not accept the necessary and sufficient conditions as 'sufficient'. In the post-classical person-centred therapies, the therapist often becomes an agent who promotes additional activities and processes that are viewed as facilitating growth. Therapists have intentions to influence clients in a particular way, and are explicit about process directivity (Brodley, 2006).

Lietaer (2001) presents a multidimensional concept comprising:

- *positive regard:* the affective attitude of the therapist toward the client;
- *non-directivity:* an attitude of non-manipulation of the client;
- *unconditionality: constancy* in accepting the client.

Lietaer offers a more 'precise' definition of 'unconditionality' as the therapist 'valuing the deeper core of the person, what she potentially is and can become' (pp. 92–3). He concludes with a conceptualization compatible with the classical view by indicating that UPR 'helps the client to become more inner-directed,

more trusting of his organismic experience as a compass for living and hence to become a better "therapist for himself"' (p.105). The two views differ, however, in just how this is to be accomplished. Lietaer moves from the classical view in his more explicit notion that the therapist's task is that of attempting to 'maximize the experiential process of the client' (p. 99).

Lietaer summarizes the sentiments of some 'client-centred/experiential' adherents when he claims that 'confrontational interventions have increasingly obtained a place within Client-Centred Therapy' (2001, p. 99). Even though Lietaer (2001) and other person-centred therapy authors (Hendricks, 2001; Iberg, 2001) advocate an instrumental use of UPR as a way of preparing clients for 'real' therapy, there is general compatibility with the classical approach in adhering to a respect for the client's self-direction. However, the fact remains that there is a substantially different view of UPR in post-classical therapies in relation to Rogers' theory of therapy. And these different views have implications for practice.

Research

Quantitative research on UPR within the person-centred paradigm has generally been examined along with the other 'necessary and sufficient conditions'. Studies of UPR as a separate variable are, however, quite sparse. UPR in research has been considered to be 'conceptually difficult to handle as a single variable' (Barrett-Lennard, 1998, p. 81).

Patterson (1984), in a critique of research reviews, re-evaluated and summarized the research studies on the core conditions, including those on UPR, to conclude that there is strong evidence for the therapist conditions as necessary and sufficient. Later reviews reiterate this conclusion (Bozarth, Zimring, & Tausch, 2002; Page, Weiss, & Lietaer, 2002; Watson & Steckley, 2001).

Another examination of quantitative research reviews is moderately supportive (Farber & Lane, 2002). These authors conclude that there is 'considerable variance in the findings linking positive regard to outcome' (p. 192). Their assessment is that positive regard seems to be associated with therapeutic success; however, they report modest effect sizes (a more recent review by Farber and Doolin, 2011, confirming this conclusion). Hence, Farber and Lane conclude that UPR 'is a significant but not exhaustive part of the process-outcome equation' (2002, p. 191). Their conclusions are, however, somewhat clouded by the focus on positive regard rather than upon UPR, and with the insertion of research not associated with Rogers' theory. Constructs from other therapeutic premises include 'therapeutic support', 'therapeutic alliance' and 'client affirmation' that result in a murky mixture of other theoretical stances in relation to Rogers' hypothesis.

Watson and Steckley (2001) conclude that there is 'a wealth of information that points to the potency of UPR as well as to other relationship conditions in promoting healthy development and growth' (p. 193). This is an important conclusion in that the authors consider some of the major problems of measuring and examining the concept. The quantitative research studies demonstrate the importance and valid-

ity of the concept. However, the authors also point out that such studies do not adequately allow a study of the interactive influences between therapist and client, nor do they capture the essence of non-linear relationships. They suggest that qualitative research is also needed.

In general, more systematic controlled designs, improved measurements and consistent operational definitions are needed in quantitative and qualitative research designs. The many therapy transcripts examined by Rogers and colleagues since the beginning of client-centred therapy are actually qualitative examinations of what goes on in therapy (Farber, Brink, & Raskin, 1996). However, they generally do not refer to particular qualitative research designs.

Brodley and Schneider (2001) provide transcripts by Rogers to demonstrate UPR communicated through verbal behaviour. The power of the *empathic understanding response* as an acceptance of the client's frame of reference implies total acceptance of the client. Brodley and Schneider also point out that 'acceptance' (or UPR) is communicated indirectly through the therapist's impartial, whole expressions and through syntax, choice of words and the general manner of communication, perhaps most easily understood as the non-verbal behaviour and presence of the therapist. Tone of voice and body language are noted as conveyers of verbal behaviour. Unconditional acceptance is also communicated 'by the absence of certain kinds of communications from the therapist's frame of reference' (p. 155), such as interpretations, leading questions, confrontations and suggestions.

Several other qualitative studies have examined clients' perceptions. The results generally suggest the positive effects of clients feeling understood, accepted, self-validated and safe to self-disclose (Bachelor, 1988; Freire, 2001; Freire, Koller, Piason, & Silva, 2005).

From theory to practice

Translation of the concept of UPR into practice varies between, and among, the classical and the post-classical therapies. The person-centred therapies, including the classical approach, are all predicated on Rogers' theoretical assumption that it is the client who has the capacity and resources to resolve her own problems. The classical approach honours this assumption through an emphasis on the 'qualities of the relationship between client and counsellor' (Merry, 2004, p. 30).

Post-classical person-centred therapies also honour the assumption of client self-direction through the qualities of the relationship, but there are also intentions to direct, guide and encourage clients towards particular experiences that are deemed therapeutic by the therapist (Brodley, 2006). These differences have implications for the role of UPR in the person-centred therapies.

Rogers' 'instructions' to therapists in his 'conditions of the therapeutic process' are that the therapist be congruent in the relationship and be *experiencing* not only UPR towards the client, but also an *empathic understanding* of the client's inner frame of reference. To be accurate, therapist congruence must always include the exper-

iencing of UPR and empathic understanding (Rogers, 1959). The delineation of these two conditions as separate variables implies that UPR and empathic understanding are separate. However, they are both explicitly identified as necessary to be perceived by the client (condition 6).

Rogers seldom, if ever, theoretically discussed empathy (used interchangeably with 'empathic understanding') without referring to UPR or synonyms such as 'warmth', 'acceptance' or 'prizing' (Bozarth, 2001b). Rogers consistently offered high percentages of empathic understanding responses in his therapy sessions. The preponderance of empathic responses conveys acceptance of the person by operationally removing judgemental communications and efforts to influence the client's direction.

An example to illustrate the sufficiency of UPR involves a woman who was a client with me nearly 25 years ago and whose therapy I wrote about over 20 years ago (Bozarth, 1984). She was a graduate student who asked to enter therapy with me because she 'wanted to be'. In general terms, three scenarios of behaviour took place over the sessions, described in Box 12.2.

Box 12.2

Wanting to be me

First, my client often walked around the large office, walking on chairs and the table, expressing herself with statements such as 'I want to beeeeee [buzzing like a bumblebee]. I want to beeee freeee.' My experiencing was that of her being free during those moments. I could imagine myself saying something like 'Free like a bumble bee', but I am not sure that I actually made that statement.

Second, she would go into what can be described as a 'catatonic' state. She would sit motionlessly in silence for an hour or longer, and then suddenly get up and leave saying, 'Thank you.' I would mumble something now and then depending upon my anxiety level. Otherwise, I would sit in silence with her.

Third, I found that I sometimes entered my client's fantasies. She once fantasized about going around the building on a homicidal binge. She would use a BB gun, a rifle and a shotgun to go from office to office. I joined her fantasy, imagining I was walking around the building with her and even carrying one of her weapons, while I might say something like 'Blood all over THAT white shirt.' I was experiencing her wish to rid herself of all critics.

She discontinued therapy when she graduated and moved to another city. We saw each other several years ago, and she said that she was now happy and successful. Briefly, we discussed our therapy sessions. She said of her sessions with me that she had 'never felt so confirmed and unconditionally accepted before' and *that* made a difference in her life. She reaffirmed this belief a few months before this chapter was revised.

The following scenario emphasizes UPR as being 'sufficient' as an intrinsic attitude of the therapist in the interaction. Freire (2001) discusses therapy interactions with 'Rita'. Rita was a 45-year-old Brazilian housewife who came to therapy because she had a fear of water. She would not drink or wash her head with water, and she wanted the therapist to resolve her problem for her. The unique relationship of the therapist experiencing UPR is explained:

> I only 'walked' with her, following her self-direction, going with her at her own pace. I trusted her self-determination. I did not try to diminish her desperation, fear or powerless feelings. To the extent that I was fully present with her as she experienced these feelings, I accepted the feelings. It was never my intention to change her or her feelings …. To me, her panic; her desperation and depression were acceptable parts of her. (p. 146)
>
> Rita lost her fear of water after the first few weeks of therapy. Four months after coming to therapy, Rita decided to stop therapy. She had 'deeply changed her personality, opening herself to feelings of fear and vulnerability. She discontinued forcing herself to be so powerful and strong … [Rita] was more open to others and improved the quality of her interpersonal relationships. (p. 147)

Freire's sessions with Rita depict a classical therapist's effort to place no constraints upon the client. She maintains her presence as total receptivity of the client's frame of reference, never attempting to resolve the client's problem or counter her powerless feelings. She accepts the client at all levels while 'experiencing a warm acceptance of each aspect of the client's experience being a part of the client' (Rogers, 1957, p. 100). It was by UPR being the distinct feature of her therapy that Rita was able to reintegrate previously denied experiences into her way of being in the world.

Self-instructions for therapists interpreted directly from Rogers' (1959) theory of therapy would be something like the following:

- Be congruent in the relationship. Maximize your own unconditional positive *self-regard*. It is ultimately the therapist's psychological development that enables the therapist to create an atmosphere of UPR to be perceived by the client. This is accomplished through the relationship with others who provide UPR.
- Maximize your attitude of UPR through your empathic experiencing of the client. Focus extensively on the client's frame of reference. Keep asking yourself, 'What is it like for this person?' It is when the client realizes that the therapist thoroughly understands and accepts the 'good, bad, and the ugly' of her frame of reference that she is free to accept herself with unconditional positive self-regard.
- Trust the client to develop her own direction at her own pace, and in her own way. This requires letting go of presuppositions of what might or should happen in any given session.

Critical reflections for the future

Critical reflections for the future lie in the differences between UPR (as interrelated with Rogers' other five conditions) being viewed as 'sufficient' or 'not sufficient'. When UPR is not considered sufficient, the thrust of therapy is shifted to 'something more' that consists of either specific techniques or some form of therapist guidance/direction/intervention that replaces UPR as the central therapeutic factor.

A critical question for the theory and practice of Rogers' theory of therapy is raised here: is UPR the 'curative' factor in Rogers' theory? The contention, from the classical perspective, is that UPR as the curative factor is the only valid conclusion if one accepts the theory of 'client-centred therapy' as expressed in Rogers' (1959) work. Acceptance of this leads to other considerations for the future. For example:

- Is the therapist's unconditional positive self-regard during the session the fundamental influence resulting in the development of the client's UPR?
- Does the unconditional positive self-regard of the therapist stimulate *therapist congruence*? Or is perhaps unconditional positive self-regard synonymous with congruence? (See Roger's summary of the theory for its application to family life; Rogers, 1959.)

One consideration for the future might lie in the definition of positive regard as making a difference in the experiential field of the therapist that is stimulated by the client's self-experiences. The UPR of the therapist is not that of applying or offering or using UPR towards the client. *The therapist is experiencing and receiving the client in a way that makes a positive difference to the therapist*. This is more than an acceptance of the client's experience, feelings and cognition at any given time. It means that the experiencing therapist is 'receiv[ing] in the organism the impact of the sensory or physiological events which are happening at the moment' (Rogers, 1959, p. 197), including 'more complete and accurate symbolization' (p. 196). The therapist is more than a passive, interested and understanding individual. The experiential world of the client 'makes a positive difference' in the therapist's experiential field.

The client's self-experiences affect the therapist in a positive manner. Subsequently, the therapist *does* just like, prize and respect 'all' aspects of the client; the therapist is positively affected by the client. This reverberates with Bown's thesis that the process of therapy is 'synonymous with the experiential relationship between client and therapist' (Rogers, 1951, p. 172). It may also be consistent with the view that therapists should attend to their own experiences in their interactions with clients (Hendricks, 2001), an act that is part and parcel of congruence in Rogers' theory.

Conclusion

The client's perception of UPR communicated through *empathic understanding* on the part of a *congruent* therapist is the basis of the client–therapist interaction process of Rogers' theory. These therapist conditions (along with the contact between therapist and client, the client's incongruence and the *client's perception* of the therapist's attitudes) are

'necessary and sufficient' for therapeutic personality change. From this standpoint, no other conditions are needed. It is clear from Rogers' (1959) theory of therapy that the thrust of the therapy is 'to create a climate where there are no constraints upon the client and therefore they are able to reintegrate previously denied experiences into their way of being in the world' (Baker, 2004, pp. 90–1). This climate is created by the client's perception of the congruent therapist's experiencing of UPR and empathic understanding.

Generally, the role of UPR in the post-classical person-centred therapies is the following:

- It is considered preliminary in that it is 'a safety-inducing element of the relational context within which the real therapeutic work is then accomplished' (Lietaer, 2001, p. 104).
- It is dependent, in large part, on the client's level of experiencing (Purton, 2004, p. 49).

The post-classical therapies, although valuing the client's view of the world and the client's self-direction, do not consider the conditions to be *sufficient*. Thus, UPR has a different role in the therapeutic process.

Despite the significant general commonalities (the focus on client involvement, empathy and acceptance, and the fact that they are generally amenable to the idea that the client has the resources to direct her own problems) that are present among the person-centred therapies, a tension exists in relation to whether the core conditions, especially UPR, are necessary and sufficient. As noted, this has implications for therapeutic practice.

So the critical reflections for the future that cut across all of the person-centred therapies are the determination of whether or not UPR is the 'curative factor', and the extent to which clients are able to pursue their own direction, pace and way.

Points for reflection

- Do you agree with Rogers' theory that human beings have a need for positive regard? If so, where do you think this need comes from?
- 'UPR is the curative factor in person-centred therapy.' Discuss.
- To what extent do you agree with Rogers' theory that the core conditions, including UPR, are necessary and sufficient for therapeutic personality change to take place. If you disagree, what is the basis of your disagreement?

Key readings

- Bozarth, J. D. (2008). Client-centered therapy and the person-centered approach. In K. Jordan (Ed.), *The quick theory reference guide: A resource for expert and novice mental health specialists* (pp. 63–81). New York: Nova Science.

This synopsis of client-centered therapy and the person-centered approach proposes that six of Rogers' publications form the foundations of the theoretical constructs. Individual contributions, key concepts, the nature of the therapeutic relationship, and limitations and strengths constitute the substance of the chapter.

■ Bozarth, J. D. (2009). Rogerian empathy in an organismic theory. In J. Decity & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 101–12). Cambridge, MA: MIT Press.

This contends that the non-evaluative, and acceptant, reception of empathy is conceptually similar to Rogers' description of UPR.

■ Bozarth, J. D., & Motomasa, N. (2005). Searching for the core: The interface of client-centered principles with other therapies. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology* (pp. 293–309). Ross-on Wye: PCCS Books.

This chapter holds that the client's perception of the therapist's experiencing of UPR (and empathy) connects to the client's constructive organismic direction.

■ Bozarth, J. D., & Wilkins, P. (Eds.). (2001). *Unconditional positive regard. Rogers' therapeutic conditions: Evolution, theory and practice*. Vol. 3. *Unconditional positive regard*. Ross-on-Wye: PCCS Books.

Chapters represent the various perspectives on UPR, including research reviews and disagreements among some advocates.

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13 Congruence

JEFFREY CORNELIUS-WHITE

This chapter discusses:

- Congruence for Rogers, including realness, matching awareness and experience, congruent communication, and expanded ideas of congruence
- Other central concepts of congruence such as organismic integration, presence and the paradox of autonomy and interconnectedness
- Congruence as flow, disciplined spontaneity, bodily felt, diversity and authentic encounter
- Reflections for the future of becoming a fully integrated and engaged person to become the change one wants to see in the world

> Be the change you wish to see. (Mahatma Gandhi, 2001)

Congruence is perhaps the most difficult concept to understand, facilitate, develop, measure and agree upon within the person-centred approach. Rogers' explanations of congruence are rich, and many recent writings offer clarifications and developments (see, for example, Bozarth, 1998; Brodley, 1998/2001; Haugh, 2001; Schmid, 2001; Seeman, 2001; Wyatt, 2001a, 2001b). Congruence refers to the internal, relational and ecological integration of persons. It is a 'broad-based construct that describes who we are and who we may become' (Seeman, 2001, p. 211).

Central concepts

Rogers' congruence

Rogers uses 'congruence' interchangeably with several other terms (for example, real, genuine, transparent, and so on). He first mentioned congruence in 1951,

but precursors are to be found as early as 1939 with an understanding of self as a necessary qualification of the therapist. Rogers wrote about the therapist's 'genuine interest in the client' and how 'the counsellor is deeply and genuinely able to adopt these attitudes' (1946, p. 421). In 1951, Rogers first introduced congruence in his personality theory, referring to the consistency between the ideal self and the self (Rogers, 1951, p. 142; see also pp. 525–32), and in 1954 he advocated therapists finding 'their genuine reality' (Rogers, 1961, p. 33).

By the late 1950s, Rogers had drawn from the earlier work of Seeman (2001) in promoting the significance of the 'degree of integration' of the therapist, placing congruence as one of the core conditions of therapeutic change (p. 201). He saw this condition as the 'growing edge' of the theory (p. 214). Rogers' (1957, 1959) third condition for therapeutic personality change is 'That the second person, whom we shall term the therapist, is *congruent* in the *relationship*' (Rogers, 1959, p. 213, emphasis added). He writes:

> This means that the therapist's symbolization of his own experience in the relationship must be accurate, if therapy is to be most effective … he should accurately 'be himself' in the relationship whatever the self of that moment may be. (p. 214)

Thus a person is called congruent when the self allows experiences to be accurately symbolized, a matching between self and experience. Rogers (1959) used the term 'symbolization' synonymously with 'awareness': 'Awareness is thus seen as the symbolic representation … of some portion of our experience' (p. 198). He goes on to say that the symbols we use may not accurately 'constitute our awareness' and may not accurately 'match … the "real" experience' (p. 198). If this were the case, there would be a state of incongruence. Rogers recognized that how a person makes sense of their experience is shaped by 'past experiences', shaping our awareness of our future experiences (pp. 198–9).

To illustrate this: As I greet my client, I notice that she does not make eye contact with me as she normally does; I feel a chill inside me, some apprehension, and I wonder what this means. Here I am accurately symbolizing 'apprehension' and 'wondering what this means' and I have an openness to what might unfold. I am in a state of congruence. However, if when experiencing the chill and apprehension, I make sense of this from my past experiences of feeling a failure when people withdraw and reject me by symbolizing, 'She's cross with me, she thinks I am no good, and she's going to leave', this may be a state of incongruence. It would only be congruent if my client actually were angry with me, did want to leave and I had been inadequate! Such incongruence could well restrict and influence how a therapist behaves with a client.

Congruent communication and way of being

In his theoretical statements of congruence, Rogers (1957, 1959) names experience and awareness as the two processes that may or may not be congruent. However, in

some discussions, he adds a third process arising out of 'freely' being the feelings that emerge (1957, p. 97) and 'accurately being himself in the relationship, whatever the self of that moment may be' (1959, p. 214). Here congruence now becomes a matching between experience, awareness and the therapist's expression or communication. The following two quotes illustrate this 'three process' model of congruence.

> I have found that the more I can be genuine in the relationship the more helpful it will be. This means that I need to be aware of my own feelings, insofar as possible, rather than presenting an outward facade of one attitude … Being genuine also involves the willingness to be and express, in my words and behavior, the various feelings and attitudes which exist in me. It is only in this way that the relationship can have reality, and reality seems deeply important as a first condition. It is only by providing the genuine reality which is in me, that the other person can successfully seek for the reality in him. (Rogers, 1954, in Rogers, 1961, p. 33)

> Thus there is a close matching, or congruence, between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client. (Rogers, 1980, p. 116)

Using the case example above, the therapist who was aware of 'being apprehensive' 'and wondering what was going on' might behave warmly and openly. She might have a look that conveys a little curiosity. She might express her experience directly with the client. For example, if the client was talking about a friend who had told her about how distant and rejecting the client had been, the therapist might make a statement of understanding and disclose how she experienced the client. She might share, 'When you arrived today, I felt apprehensive and chilled. I noticed that you didn't look at me as you usually did, and I wondered what was happening for you.' As a result, the client may feel understood and explore with depth how she disconnects from people, and the results of this for herself and others. In this example, the therapist's experience, awareness and expression are congruent.

However, the incongruent therapist, operating not from congruent experience of empathy and awareness but interpreting 'She's cross with me, she's going to leave because I'm not a good therapist', may have conveyed withdrawal and defensiveness. She might have turned away from her client. When the therapist spoke, her voice might have been a little hesitant and cold, while her eyes portrayed a distant look as if she had lost some of her 'aliveness'. During the session, the client might have spoken less, staring down at the floor. The therapist's experience, awareness and expression could be said to be incongruent as she inaccurately symbolized the experience of feeling 'chilled' and 'apprehensive' from her past experiences. She interpreted her experiences in such a way that she felt a failure and thought she was about to be rejected.

There has been much debate within the person-centred community regarding when it is appropriate for the therapist to communicate his or her own thoughts and feelings to the client. Rogers suggests it is when the therapist loses their empathic

understanding and unconditional positive regard as a result of the therapist's preoccupation with his own feelings. He cautions, 'Certainly the aim is not for the therapist to express or talk out his own feelings, but primarily that he should not be deceiving the client as to himself' (1957, p. 98).

Another aspect within Rogers' writings on congruence that is particularly relevant here is the 'integration', 'realness' or 'wholeness' of the therapist as this will influence the relationship between the therapist's experience, awareness and expression. The more actualized the therapist, the more experiences that will be accurately symbolized into awareness. Rogers speaks about being an 'integrated person', to 'be himself' (1957, p. 97), and 'that for therapy to occur the wholeness of the therapist in the relationship is primary' (1959, p. 215). Rogers (1957) used phrases such as to be 'freely and deeply' (p. 97), 'endeavouring, to the best of his ability' (Rogers, 1959, p. 214) and to become 'completely and fully' his or her unique organism (p. 215) to convey this broader and more holistic aspect of congruence. Congruence is a work in progress in which an 'individual appears to be revising' himself through 'openness to experience' (Rogers, 1959, p. 206) in a 'fluid and changing gestalt, a process' (p. 200).

Rogers states, 'The wholeness of the therapist in the relationship is primary, but a part of the congruence of the therapist must be the experience of unconditional positive regard and the experience of empathic understanding' (p. 215). This meta-condition idea has been developed recently by others in that empathy, unconditionality and congruence are 'functionally one condition' (Bozarth, 1998, p. 80), 'one fundamental way of being, relating and acting' or '*the* encounter condition' (Schmid, 2001, p. 220–1). This is supported by Sherer and Rogers' (1980) study finding that, at the measured non-verbal level, the three conditions were highly interrelated.

Aside from two- and three-level matching and integration, Rogers (1959) describes different dimensions of congruence and clarifies their relationships:

> Congruence is the term which defines the state. Openness to experience is the way an internally congruent individual meets new experience. Psychological adjustment is congruence viewed from a social point of view. Extensional is the term which describes the specific types behaviour of a congruent individual. Maturity is a broader term describing the personality characteristics and behavior of a person who is, in general congruent. (p. 207)

He elaborates upon the technical term 'extensionality' to convey how the open, mature, adjusted person interacts with not just themself or others, but with the world. This way of being and doing has important implications for understanding congruence as complex and pluralistic. The extensional person tends 'to be aware of the space-time anchorage of facts … to evaluate in multiple ways … [and] to test his [or her] inferences and abstractions against the world' (Rogers, 1959, pp. 206–7). Extensional behaviour interacts with reality and personal perceptions rather than denying or distorting interpretations or belief systems. More importantly, it attempts

to engage the complexity of life (like Rogers' attempts to explore the complexity of congruence itself) through multiple vantage points and empirical and phenomenological methods. There is no one right way to be congruent. There is only a fluid process that appreciates one's self, others and the world as it is in that moment-to-moment encounter.

Seeman's organismic integration

Seeman's human systems approach to congruence (2001) developed Rogers' broader construct. This was more frequently termed 'organismic integration'. Whereas Rogers referred to experience, awareness and communication, Seeman's system's approach extended this to multiple levels and processes: the biochemical, physiological, perceptual, precognitive, cognitive, interpersonal and ecological. These multiple levels and processes are linked through 'connection and communication'; the connection between the multiple levels and processes is the 'structure' whilst the 'communication' or 'resulting flow of information' between the different dimensions is the function. As a result multiple levels of the system mutually influence each other (pp. 204–6). Seeman conducted 25 studies, finding that organismic integration is characterized by a 'horizontal egalitarian style in contrast to a vertical status-oriented style of interpersonal behavior' (pp. 208–9). Similar to Rogers' extensionality, Seeman describes how an important aspect of congruence is 'to receive and process the reality data of their world'. Congruent people fully engage and extensionally respond to the world at every level of being and becoming.

Wyatt (2001a, 2004), Haugh (2001) and Ellingham (2001) offer further elaborations of a holistic conception of congruence, in which the process of connection and communication occurs across multiple levels. They each critique Rogers' less process-oriented conceptualization of congruence, which involves uncovering experience of which person was unaware. Rather than involving pre-existing experience, Haugh (2001) clarifies that, in congruence, a process 'completely new has been created, not that something new (but already existing) has been perceived' (p. 127). Congruence as this sort of emergence has clear roots in Rogers' process descriptions and Seeman's human systems conceptualizations beginning in the 1940s (Seeman, 2001). However, it is particularly difficult to articulate and maintain given the prevailing cultural, linear paradigm grounded in our language. Presence offers a possibly useful construct beyond our usual linear paradigmatic language that expresses the 'multi-faceted nature of congruence' (Wyatt, 2001a, p. 79).

Congruence and presence

Congruence is sometimes believed to have evolved into (Adomaitis, 1992) or been consumed by (Greenberg & Geller, 2001) the concept of presence. In an interview with Baldwin (1987) at the end of his life, Rogers stated, 'Perhaps I have stressed too much the three basic conditions (congruence, unconditional positive regard and

empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is clearly, obviously present' (p. 45).

Rogers (1980) also stated:

> I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing. Then, simply my presence … [or the] transcendental core of me [in which] our relationship transcends itself and becomes a part of something larger … [is where] profound growth and healing are present. (p. 129)

Hence, a presence conceptualization of congruence refers to an authentic, empathic and unconditional integration involving both the intuitive and the transcendent. When truly present, spontaneous expressions of one's own transcendent person in connection with others are poignantly facilitative. As with the findings on empathy, unconditional positive regard and congruence, measurement of the client's perspective on presence appears to be a better predictor of outcome than the therapist's perspective (Geller, Greenberg, & Watson, 2010). (For more on presence, see Chapter 14.)

Autonomy–interconnectedness

The foundation of Rogers' (1959) theory is the actualizing tendency (see Chapter 6), the inherent inclination 'to maintain and enhance the organism' (p. 196). At one level, congruence is the process of actualization, or a person's 'development toward autonomy' (Rogers, 1959, p. 196). When internally integrated, a person moves away from being controlled by or controlling others. However, Rogers' later discussion of presence as transcendental implies moving beyond the limits of the individual.

Rogers introduced the formative tendency to explain this motivation beyond the individual towards interconnection. The formative tendency applies to both people and non-people and is a general inclination for things to develop and become more complicated and interactive. Rogers elucidates how 'a formative directional tendency in the universe' (1978, p. 26):

> exhibits itself as the individual moves from … knowing and sensing below the level of consciousness, to a conscious awareness of the organism and the external world, to a transcendent awareness of the harmony and unity of the cosmic system, including humankind. (Rogers, 1980, p. 133)

He also clarifies the motivational structure of the person-centred approach as 'an evolutionary tendency toward greater order, greater complexity, greater interrelatedness' (Rogers, 1980, p. 133).

Rogers did not see this change from an actualizing approach within therapy to a formative approach within the world as a shift, but instead as a deepening and

extending, stating about client-centred therapy and the person-centred approach that they are not 'different in me' (Rogers, Cornelius-White, & Cornelius-White, 2005, p. 394). Hence, the actualizing and formative tendencies taken together indicate that to be congruent means to be aware and integrated not only in autonomy, but also in an ecological connection (Cornelius-White, 2007a). Similarly, Schmid (2001) summarizes congruence as the 'two unrenounceable dimensions of [authentic] human existence: the substantial or individual aspect of being a person and the relational or dialogical aspect of becoming a person' (p. 214).

From theory to practice

Summary of research related to therapeutic outcome

Lietaer (2001, p. 41) writes, 'Personal maturity, together with the basic clinical aptitudes related to it, can thus be considered as the therapist's main instrument in client-centred therapy'. Thus, congruence is a broad intrapersonal and interpersonal concept that is difficult to measure but central to the success of person-centred therapy. However, it has be reduced to a simpler construct in quantitative outcome studies, from which congruence appears 'probably effective'. It has been shown to have a more modest impact than empathy, respect or overall relationship (Cornelius-White, 2007b; Klein, Michels, Kolden, & Chisolm-Stockard, 2001). When, however, viewed within the relationship from the client's perception of realness rather than an observer's, congruence reaches the 'demonstrably effective' threshold (Cornelius-White, 2002).

Kolden, Klein, Wang and Austin (2011) conducted a meta-analytic review of therapist congruence in relation to client outcomes. They found 16 studies, involving a total of 863 clients, with statistics sufficient for inclusion. The overall effect size was $r = 0.24$, a medium effect size. In addition, outcome research suggests that 'it is the absence of incongruence and phoniness that contributes to good therapy' (Grafanaki, 2001, p. 20). Hence, at the most basic level, the practice of congruence is the practice of realness. Therapists aim to be real by first just not faking or playing a role. However, they develop personal maturity through practising and becoming a way of being that facilitates both themselves and others to live in a fully engaged process. This involves internal congruence, communication, a sense of flow, disciplined spontaneity, body awareness and an encounter stance to the world.

Internal congruence and communication

Rogers' internal congruence is based upon self-awareness, or accurate symbolization of experience. A congruent person is in a process of understanding and accepting each of their perceptions and reactions as they occur. In other words, a therapist has empathy and unconditional regard for his or her own experiencing. Therapist self-acceptance is hypothesized to lead to unconditional empathy towards others and helps others to realize it within themselves.

At the most important level, congruence, like unconditional regard, is rarely communicated deliberately in words (Brodley, 1998/2001). People pick up on levels of congruence based on body language far more than they do on words. In a contest of the 'do' versus 'say' to figure out if someone is real or not, the 'do' almost always wins. Tepper and Haase (1978) found that empathy is twice as communicated, respect is five times more communicated and congruence is 23 times more communicated by non-verbal cues than verbal ones. Hence, communicating congruence is primarily a non-verbal byproduct of being internally congruent. Non-verbal communication is largely unconscious. Nevertheless, people are interpreted differently than they intend, even when congruent, which is where live and videotaped supervision and encounter groups become helpful. Therapists can learn how they are perceived and become better at allowing their non-verbal communication to be accurately received.

However, there may be times when therapists are more deliberately verbally communicative of their congruence. Rogers (1959) writes that if a therapist is 'persistently focused on his own feelings rather than those of the client, thus greatly reducing or eliminating any experience of empathic understanding, or … unconditional positive regard', the therapist should express them (p. 214). Hence, if being distracted by one's own process is inhibiting empathy and understanding for another, it may be practical for therapists to express an aspect of their experience.

Likewise, Rogers (1959) wrote that verbal communications of congruence occur in such as way as to 'never contain an expression of an external fact … [and are spoken] in a context of personal perception' (Rogers, 1961, p. 341). Therefore, deliberate communicative congruence often takes the form of an 'I statement' in which an internally accepted personal feeling or reaction is offered about an event that is consensually agreeable to have happened (factual). A statement such as 'I feel you are being unfair' does not include a personal perception or potentially factual explicit or implicit referent and is not likely to be an expression of congruence. The statement 'I feel sad when I hear you speak about your mother' appears to be accepted by the therapist as an experience, and does include a personal feeling (sadness) and a referent that the listener is likely to understand (speaking about mother). Practice in groups where encounter is possible and discussion in supervision are ways to develop the ability to express congruence through self-disclosures, which often take the form of 'I-statements.'

Congruence and flow

Being and becoming the process of congruence is sometimes described in practice as an experience of flow. Counsellors often describe 'their experience in relational terms, and placed particular emphasis on the therapeutic value of achieving a state of "flow," in which counsellor and client were congruent and co-present with [or encountering] each other' (Grafanaki, 2001, pp. 30–1). Rogers stated that, to be authentic, 'you have to feel entirely secure as a person … [and] surrender yourself to a process' (Baldwin, 1987, p. 50). Feeling 'secure as a person' means learning to accept both your own vulnerability and personal power.

From studies of peak and fulfilling experiences, Csikszentmihalyi (1998) is responsible for popularizing and described the concept of flow. Csikszentmihalyi's flow has several characteristics that are similar to how the experience of congruence is sometimes described. Flow is characterized by a clear preparation of goals. Greenberg and Geller (2001) term this aspect of congruence 'preparing the ground' or 'bracketing irrelevant experiences'. If a therapist notices her hand twitching before a session and begins to reflect, thinking that she is usually quite comfortable with this particular client, she may realize that she is nervous about a presentation she will be giving later in the day. In this situation, she can recognize and hold this part of her experience in such a way that removes it from the immediate situation and allows more of her to be present in the actual encounter she is about to enter.

Flow also includes a sense of concentration. Grafanaki (2001) describes the practice of congruence as being entirely focused upon the shared relational experience. Flow involves a loss of self-consciousness. Wyatt (2001a) discusses how self-consciousness fades in the transcendent congruent encounter experience. Bozarth (2001) terms the lack of self-consciousness of congruence 'unconditional positive self-regard'. Flow is feeling alive and feeling that experience as intrinsically rewarding. Greenberg and Geller (2001) portray the practice of congruence as being attuned to the experiences and meanings that are most poignant to the client.

Disciplined spontaneity

Another way to realize congruence is through the practice of 'disciplined spontaneity' (Lietaer, 2001). Rogers (1967) wrote, 'I believe it is the realness … when the therapist is natural and *spontaneous* that he seems to be the most effective' (p. 185, emphasis added). Hence, the realness aspect of congruence is not only the fundamental process of not being phoney, but also just being who one is. This is a matter of not just accurate symbolization, but also organismic integration, presence and flow. Rogers (1967) continues, 'The person who is able to openly be himself at that moment, as he is at the deepest levels he is able to be, is the effective therapist. Perhaps nothing else is of any importance' (p. 186). Here, he suggests that congruence is a quality of free intuitive interaction of the psychologically mature. Hence, congruence evolved to include self-disclosure (Lietaer, 2001).

Nevertheless, communication of congruence is also a 'trained humanness' (Rogers, 1967, p. 185). Expressing a 'natural reaction' to a client is fostered from empathy and unconditionality (pp. 185–6) and is 'embedded in a fundamental attitude of openness' (Lietaer, 2001, p. 47). Brodley (1998/2001) clarifies: 'Communications of one's self … takes care and discipline and self-control' (pp. 74–5).

While disciplined spontaneity results in idiosyncratic, emergent styles unique to each practitioner (Bozarth, 1998; Keys, 2003), they most frequently come in situations where clients ask implicit or explicit questions or relate emotionally unusual or intense experiences (Brodley, 1998/2001). Box 13.1 shows an example of a therapist's (T) response to a client's (C) explicit question.

Box 13.1

Example of a response to a client question

C: What do you feel about what I have said?

T: You want to know my personal reaction about what you told me or about my reaction towards you?

C: Both, I guess. I'm afraid your feelings about me will be different now you know I do that. I'm afraid you're disgusted by me.

T: I don't feel disgusted at all. My feelings aren't changed. I do feel a deep sadness that you want to hurt yourself.

C: Don't you feel it's sick?

T: I don't feel that. My thought about it is it's something that has come out of your suffering. Although it hurts you, it also relieves you.

(Brodley, 1998/2001, pp. 70–1)

In the example in Box 13.1, three elements are present. The therapist offers personal perceptions directly addressing the question, 'I don't feel disgusted' and 'My feelings are not changed', but also offers a spontaneous disclosure of her sadness and an empathic interpretation of dialectical aspects of the client's experience. It is also clear that an accepting, understanding, open attitude is present both in the attempt to first understand the request and in the tone of each therapist disclosure. The 'discipline', 'trained humanness' or integration of empathic acceptance and speaking from personal perception in congruent communications is present. Also present is the 'spontaneity' of an authentic self-disclosing affective (sadness) and cognitive (interpretation) response.

Bodily felt congruence

Another layer of the development and practice of congruence is bodily felt. Schmid (2001) asserts that counsellors need to 'pay attention to their clients' bodies, and their own bodies' and that congruence 'always includes the facilitation of their awareness of their body' (pp. 222–3). Mindful breathing is perhaps the oldest and most fundamental area of building mind–body awareness, the word 'breath' deriving etymologically from the same root as 'spirit'.

Hence, knowing and developing the therapist's person is a process of organismic, or mind–body–spirit, integration. Furthermore, not only body awareness, but also body health is vital for the practice of congruence. Person-centred educa-

tional research has shown that aerobic health predicts a therapist's endurance in holding the conditions, those who are not physically fit often showing a pattern of decline in the condition of presence as the day and week progress (Rogers, 1983). Finally, as our body communicates congruence 23 times more than our words, awareness of the communicative aspects of our non-verbal experience, particularly facial expression, vocal intonation, eye contact and body orientation, is salient for the practice and development of congruence (Grafanaki, 2001; Tepper & Haase, 1978).

In addition to the use of videotapes, live supervision or encounter groups described above, mindfulness meditation and training in basic non-verbal communication can be helpful. For example, these methods can foster an appreciation of what might be unintentionally communicated by the therapist who crosses her arms and tilts her head down when physically cold during a session, as seen in Box 13.2.

Box 13.2

Example of less than ideal bodily self-awareness

Client:	I'm sorry I'm late.
Therapist:	That's ok. [*adjusts in seat, looks down while speaking, and crosses arms*]
Client:	[*goes quiet*]
Therapist:	[*waits and wonders and then says*] Are you ok?
Client:	Yes, I was going to ask the same about you. I thought you were angry with me for being late.
Therapist:	Why would you say that?
Client:	I don't know. I just thought you were. [*continues with her story but in a muted, hesitant way*]

A position of arms crossed is typically received by others as a defensive, closed, scared or angry position, while a tilted-down head is most often seen when people are absorbed in their own emotions, particularly of a sad tone. The short example in Box 13.2 illustrates how a therapist's unconscious non-verbal communication can influence the therapeutic relationship. The feedback processes of reflecting in yoga on how one feels in different positions, being told in an encounter group or being advised in supervision can all enhance one's sense of how a person and others experience them non-verbally.

Cultural congruence

When congruence is understood as a multilevel construct of integration from the intrapersonal to the interconnected, this suggests that one must engage culture to develop congruence. Schmid (2001, p. 218) states that 'you cannot reflect on being congruent if you don't experience and consider diversity'. Culture is a pervasive element of persons' experiences shaping the very way in which they symbolize their experiences. For example, Ellingham (2001, p. 106) asserts that feelings and thoughts that comprise congruence are 'always a social construction, very much a product of our cultural values and language'. This author has discussed how multicultural issues impact the approach, especially surrounding individualistic interpretations and implicit cultural conditioning (Cornelius-White, 2003, 2006, 2007a; Cornelius-White & Godfrey, 2004).

Hence, understanding the pluralistic world is necessary to practise this broader construct of congruence. For example, Rogers (1977) writes about 'subtle ways of communicating' 'contradictory messages', using the example of the usage of masculine pronouns to refer to people (Rogers, 1961, p. 51) as belying a lack of congruence (Cornelius-White, 2006). Merry (2001, p. 179) offers a more clinical example:

> a therapist, whose self-picture incorporates the notion that he or she is entirely free of prejudice, would experience some level of anxiety when confronted by a client of a different ethnic group … [and] would find difficulty in allowing prejudice feelings into awareness.

In other words, the impact of a pluralistic world on understanding congruence is underappreciated. Persons understand their seemingly autonomous experience through their implicit relationships and interconnectedness to culturally similar and different others.

The authentic encounter stance

Rogers (1967) writes that the practice of 'therapy has to do with the [authentic] relationship, and has relatively little to do with techniques or with the theory and ideology' (p. 185). In other words, therapy is ultimately a connection between persons, and congruence is an authentic encounter stance that allows this connection to unfold. Schmid (2001, p. 224) declares that the 'only legitimate "techne" (the original Greek word which means "art") is im-mediacy, or im-media-te presence (presence without media), in other words, the encounter person to person'. This stance allows for therapist and client to be mutually vulnerable and influenced. Authenticity is not intentionally persuasive. Congruent therapists develop a tendency to calmly tolerate a degree of ambiguity and discomfort and do not 'ask anything more of the client than to also be present' (Greenberg & Geller, 2001, p. 148). In essence, 'therapy is a process to overcome preconceived techniques and methods (which always come in between humans) by making them superfluous' within the authentic encounter (Schmid, 2001, p. 224). In the end, the practice of congruence is the lived experience of the authentic relationship encounter.

Conclusion: Becoming the change you want to see in the world

It is our 'response-ability' to respond and fully engage the world at every level of our being and becoming (Schmid, 2001, p. 217). The practice of congruence leads to a sense of acceptance, understanding and integration from the internal to the relational and ecological. In this way, congruence is the core condition of the person-centred approach, realized not only or most importantly in therapy, but in our every action. It is 'obvious that the approach needs further development towards a truly social approach' and to 'authentically implement the essence of it into all fields of life' (Schmid, 2001, p. 226; see also Proctor, Cooper, Sanders, & Malcolm, 2006). Congruent people engage themselves in awareness, others in encounter, and the world with extensionality. With reference to the words of Gandhi at the start of this chapter, congruence is being and becoming the change you want to see in the world.

Points for reflection

- How does the idea of one meta-condition comprising sincere empathy and respect for one's self and others focus and/or expand your self-awareness?
- How do the various descriptions of congruence help you deepen your understanding of your self in interaction with the world?
- What is one meaningful way in which you can change your practice of congruence to further facilitate your clients or others?

Key readings

- Johnson, D. W. (2008). *Reaching out: Interpersonal effectiveness and self-actualization* (10th ed.). Boston: Allyn & Bacon.

D. W. Johnson, together with his brother R. Johnson, has conducted more research and been a more effective advocate for cooperation in education and professional development than anyone. This book, now in its 10th edition, provides in any edition a wealth of 'how-to' suggestions on developing one's maturity, personal integration and moment-to-moment self-awareness in relation to others. They also run a website: www.co-operation.org.

- Wyatt, G. (Ed.) (2001). *Rogers' therapeutic conditions: Evolution, theory, and practice*. Vol. 1. *Congruence*. Ross-on-Wye: PCCS Books.

This volume, edited by Gill Wyatt, is published by PCCS Books as Volume 1 of the series on the core therapeutic conditions. It provides 360-degree coverage of the topic. Even though it is a decade old, it still provides both classic and innovative conceptions and discussions from a variety of international sources. It challenges readers to consider a variety of conceptualizations and aids them in the lived experience of congruence.

■ www.pce-world.org

The World Association for Person-Centered and Experiential Psychotherapy and Counseling provides a rich website with public and member-only access to a wide variety of theoretical and empirical articles, bibliographies and links related to congruence and the person-centred approach.

■ www.tolerance.org

This project of the Southern Poverty Law Center helps to foster self-awareness through anti-bias professional development activities. It provides teaching kits with Academy Award-winning videos, resource books and free downloadable activities to help one foster an understanding of who one is and how one interacts with others who are different.

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14
Therapeutic presence

SHARI GELLER

This chapter discusses:

- A definition and description of what therapeutic presence is … and what it is not
- Therapeutic presence as a foundation of Rogers' core conditions
- Research on therapeutic presence in relation to process and outcome
- Practical exercises to enhance the cultivation of the therapeutic presence

Therapeutic presence is a way of being that reflects therapists' full engagement in the moment-to-moment encounter with their clients. This level of being with the other allows clients to open up and explore painful issues in their lives in a safe and supportive relational connection. Therapeutic presence is essential for developing a highly attuned and mutual relational connection that can lead to effective therapy.

This chapter elucidates the subtle qualities of therapeutic presence as based in a combination of person-centred theory, clinical experience and embodied practice, over a decade of research. While presence is not a new concept for person-centred therapists, what may be innovative is discussion around the language, care, preparation and process of therapeutic presence, which can contribute to the cultivation, sustenance and therapeutic benefit of this essential therapeutic stance.

What is therapeutic presence?

Therapeutic presence is defined in part as bringing one's whole self into the encounter with a client, being completely in the moment on a multiplicity of levels, physically, emotionally, cognitively, spiritually and relationally. Presence

also involves being grounded in one's self, while receptively taking in the verbal and bodily expression of the client's in-the-moment experience (Geller, 2001; Geller & Greenberg, 2002, 2012). While this inner receptivity involves the therapist's openness to the client's multidimensional internal world, it also involves openness and contact with therapist's own bodily experience in order to access the knowledge, professional skill and wisdom embodied within. Being fully present then allows for an attuned responsiveness that is based on a kinaesthetic and emotional sensing of the other's affect and experience.

With therapeutic presence, the depth of the therapist's own being is reaching out and touching, as well as open to being touched by, the depth of the other. A relational therapeutic presence then emerges where the meeting of the two people is in the service of healing for the client, which allows for an alignment with and activation of the natural tendency towards growth (see Chapter 5). Therapeutic presence also creates a neurophysiological experience of safety in the client, which can deepen the therapeutic relationship and facilitate the client's healing (Geller & Porges, 2012).

Therapeutic presence can also be viewed as a way in which therapists monitor their own experience in therapy. Through an enhanced sensitivity to their clients' experiences, therapists can use their selves and their attuned bodily awareness as tools in understanding and responding to the client as well as to sense how their responses are facilitating the client's therapeutic process and the therapeutic relationship. The therapist's bodily sense of the client's experience is a reflection of an inner synthesis of the client's expressed and felt experience with the therapist's own lived experience and his or her professional expertise. The therapist responds from this felt place of being attuned in the moment with the client.

Therapeutic presence also allows for an optimal and healthy state for therapists. Being and practising presence allows therapists to work through and release the emotional residue associated with deep person-centred relational work, which then results in lowered stress, anxiety and burn-out.

Therapeutic presence and Rogers' relationship conditions

Research suggests that while there is a relationship between aspects of therapeutic presence and Rogers' therapist-offered conditions of empathy (Chapter 11), congruence (Chapter 13) and unconditional positive regard (Chapter 12), presence is a distinct quality that provides a foundation for these conditions. Near the end of his life, Rogers began to articulate the underlying quality of therapeutic presence when he noted that:

> I am inclined to think that in my writing I have stressed too much the three basic conditions (congruence, unconditional positive regard, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is very clearly, obviously present. (Baldwin, 2000, p. 30)

According to Rogers, being present is an embodiment of the therapeutic conditions (Baldwin, 2000).

After Rogers' death, person-centred theorists have continued to explicate presence as a possible underlying condition for the relationship conditions (Bozarth, 2001; Bugental, 1983, 1986, 1987; Geller & Greenberg, 2002, 2012; Geller, Greenberg, & Watson, 2010; Schmid, 1998; Thorne, 1992; Wyatt, 2000). What therapeutic presence appears to add to empathy, congruence and unconditional regard is the preliminary necessity of receptively being clear and open to receiving the totality of the client's and one's own experience (Geller & Greenberg, 2012). The therapist's presence can thus be viewed as the receptive condition that allows the therapist-offered conditions to emerge.

Presence and empathy

Therapeutic presence reflects being grounded and spacious within one's self while being immersed, open and receptive to the other. This grounded, receptive and non-judgemental openness to the client's experience allows therapists to be in an optimal position to empathically attune and understand clients' experience as it is expressed in the moment.

Therapists can be present without being empathic. In fact, therapeutic presence is a first step towards empathy, and is necessary for empathy to occur. In order to understand and reflect empathically what the client is experiencing, the therapist needs to first be in an open and receptive stance. Hence, the therapist can be present without being empathic, they can be present in order to be empathic, and they can be present while being empathic. However, the therapist cannot be empathic without being present. The process of empathy, then, is optimally enhanced when the therapist is first grounded in the present within his or her self and with the client, as well as open and accessible.

We understand that, to be empathic to others, one must first be able to be present with the other. However, what is important for training purposes is to understand that to be fully present with a client demands that therapists cultivate a sense of presence within themselves first.

Non-presence or absence

One way to understand presence is to explore what it means to be absent or distracted. This can include busyness before a session that prevents presence from emerging. Some examples of non-presence are listed below.

Examples of non-presence

Prior to session, there may be the following:

- busyness, moving from one session right into the next without pause;
- not listening to bodily needs such as hunger, thirst and bathroom needs;
- squeezing in email checking and calls without a moment's pause;
- stress or a feeling of being overwhelmed by one's own unresolved or ongoing issues.

During the session, there may be:

- continuous checking of the time;
- a predetermined idea of what is needed or what is 'right' for the client;
- keeping too far an objective distance from the client;
- being too enmeshed with the client and losing one's sense of self;
- self-judgement at one's own responses or misunderstandings;
- boredom, dullness or sleepiness;
- preoccupation with events or needs arising prior to or after the session;
- not hearing what client is communicating (that is, missing words or whole sentences as well as not noticing non-verbal expressions).

Post-session, the following may occur:

- lack of vitality
- fatigue
- self-criticism
- relief that the session is over
- agitation
- inner tension
- a lack of clarity or focus.

Box 14.1

A clinical vignette reflecting the barriers to presence

John wept as he spoke of the loss of his mother. He recalled an incident where he had a disagreement with his mother before her diagnosis of cancer and his incredible guilt of having walked out in an angry huff. As I was listening to him, I began to feel anxious and overwhelmed, doubting my ability to help him with his complicated grief. He further expressed his unhappiness and self-doubt about his response, and wished he could have replayed that moment differently as several weeks had passed before he spoke to his mother again, only to find out she had been diagnosed with a terminal illness.

My anxiety grew as I began to hear my own internal voice say, 'You can't help him … you don't know anything about grief … you haven't trained in this area … who do you think you are?' My responses to John were concrete and flat as I battled with the critical voices in my own head. He went silent and his tears stopped, while he shifted the conversation to the work chores he had to do. I felt the disconnection between us and did not know how to proceed.

Box 14.1 gives an example of how a therapist's self-doubt or judgement interfered with her ability to be present with one client, John. The moment of disconnect

to which the therapist is referring in Box 14.1 reflects a lack of presence and resulted in the client's silence and flat affect. However, therapists' awareness of their disconnection or non-presence can also offer an invitation to bring their attention back to the moment. Box 14.2 continues the story.

Box 14.2

Clinical vignette continued: A practice of returning to presence

When I became aware of John's shutting down and my own lack of presence and disconnection, I spent a quiet moment taking a deep breath and regulating my emotions by feeling my feet on the ground. The practice in presence that I had done allowed me to let go of my self-judgement and invite my awareness back into the room. I could then return with my full awareness to my client. I shared my noticing of my client's silent and emotional distance, and wondered if it had to do with my distancing. We shared the sense of helplessness in the face of grief, and this open and compassionate sharing not only allowed my client to open and express his layers of grief and despair, but also deepened the bond between us.

On one hand, not being present with our clients has potential harm for the process of therapy and for the client's feeling understood, heard and accepted. However, therapists' awareness of not being present can also be used to bring attention back to the moment. In this example, the inward attending and contact with self that is part of presence allowed this therapist to become aware of her disconnection and how her self-judgement had resulted in a distancing from the client. She was then able to use her presence practice to invite her attention back to the room and to open up again to the difficult feelings being experienced by her client, which also led to a repair in the relational disconnection.

Not having an awareness of being absent or not having ways to regulate and bring one's self back to the moment can actually be more harmful. Although the ideal of sustaining presence fully throughout a session is unrealistic, present moment awareness and practice can help therapists to notice when they are distracted or distancing, and to quickly realign and bring their awareness back to the client (in the example above, by grounding, breathing and letting go of self-doubt).

Research on therapeutic presence

A series of studies have been conducted that have contributed to an understanding of therapeutic presence (Geller, 2001; Geller & Greenberg, 2002, Geller et

al., 2010). The first therapeutic presence study was a qualitative study in which seven experienced therapists were interviewed on their experience of presence (Geller, 2001; Geller & Greenberg, 2002). The interviews were transcribed and subjected to a qualitative analysis, which revealed a model of therapeutic presence. The model of therapeutic presence consists of three overarching categories, reflecting the *preparation*, the *process* and the *experience* involved in being fully in the moment with a client in a therapy session. Therapeutic presence is an intense and rich experience of being fully in the moment with the client and a part of the healing process. The model of therapeutic presence is outlined in Figure 14.1 (Geller & Greenberg, 2002).

Preparing the Ground for Presence	Process of Presence	Experiencing Presence
In session	**Receptivity**	**Immersion**
Intention for presence Clearing a space Putting aside self-concerns Bracketing (theories, preconceptions, therapy plans) Attitude of openness, acceptance, interest and non-judgement	Open, accepting, allowing Sensory/bodily receptivity Listening with the third ear Extrasensory perception/ communication Inclusion Expanded or enhanced awareness	Absorption Experiencing deeply with non-attachment Present-centred (intimacy with moment) Aware/alert/focused
In Life	**Inwardly Attending**	**Expansion**
Philosophical commitment to presence Personal growth Practising presence in own life Meditation Ongoing care for self and own needs	Self as instrument Increased spontaneity/ creativity Trust Authenticity and congruence Returning to the present moment	Timelessness Energized/flowing Inner spaciousness Enhanced awareness, sensation and perception Enhanced quality of thought and emotional experiencing
	Extending	**Grounding**
	Accessible Meeting Transparency/congruence Intuitive responding	Centred/steady/whole Inclusion Trust and ease
		Being with and for the client
		Intention for client's healing Awe, respect, love Lack of self-conscious awareness

Figure 14.1 A model of therapist's presence in the therapeutic relationship
Note: Reproduced from Geller and Greenberg (2002, p. 76).

Therapeutic presence begins with *preparing* for presence, *prior to the session*, by bringing one's whole being to the moment of meeting the client. This includes an intention and commitment to therapeutic presence, with an ability to bracket expectations, theories and preconceptions, and to approach the session with an attitude of

openness, acceptance, interest and non-judgement. One way in which therapists prepare for presence is to practise it *in their daily lives* through being present with others, meditation and attention to personal growth. Therapists describe the importance of the ongoing care of self as essential to creating the opportunity to be in presence during a session with a client.

When in therapeutic presence, the therapist is involved in a moment-to-moment *process* in which the therapist oscillates or simultaneously experiences being *receptive* to the client's experience, *inwardly attending* to their own ongoing flow of experience, and *extending their inward awareness and their presence through direct contact* with the client. The therapist is ultimately guided by what is most immediate in each moment in a way that is with and for the client. The therapist receives the totality of the client's experience and uses that inner experience to understand and respond while maintaining direct contact with the client.

The actual in-session *experience* of therapeutic presence begins with therapists feeling *grounded* in themselves. From this grounded place, therapists experience being fully *immersed* in the moment with their client, while experiencing a sense of *inner expansion* or spaciousness. Being grounded, immersed and spacious is accompanied by the intent to be present *with and for the other*, being involved in a healing process in the service of the client.

The second therapeutic presence study involved the development of a measure of therapeutic presence, the Therapeutic Presence Inventory (TPI), which was based on the model presented in Figure 14.1 (Geller, 2001; Geller et al., 2010). Two versions of the TPI were created and studied: one from the therapist's perspective (TPI-T) and the other from the clients' perception of their therapists' presence (TPI-C). The TPI-T can also be used as a self-audit tool for therapists to reflect on their degree of presence with a client (Table 14.1). Each item is rated from 1 ('Not at all') to 7 ('Completely') (not shown in Table 14.1). To work out the final score, the total score of the bold items in Table 14.1 (which indicate a lack of presence) is deducted from the score for the items not marked in bold in the table (which indicate presence).

The third study of therapeutic presence demonstrated that both versions of the TPI were reliable and valid (Geller et al., 2010). Furthermore, clients' perception of their therapists' presence (TPI-C) was found to predict a positive therapeutic alliance and session outcome across person-centred, process-experiential and cognitive-behavioural therapies (Geller et al., 2010). Therapists' self-ratings were not found to relate to the alliance or session outcome, suggesting that it is clients' perception of whether their therapist is present with them that is important. Research has also suggested that therapeutic presence is predictive of the relationship conditions of empathy, congruence and unconditional regard (Geller et al., 2010). With respect to presence and empathy in particular, findings suggests that they are related yet distinct (Geller & Greenberg, 2012; Pos, Geller, & Oghene, 2011) and that presence precedes empathy (Hayes & Vinca, 2011).

Table 14.1 Items on the Therapeutic Presence Inventory

1	I was aware of my own internal flow of experiencing.
2	**I felt tired or bored.**
3	**I found it difficult to listen to my client.**
4	The interaction between my client and I felt flowing and rhythmic.
5	**Time seemed to really drag.**
6	**I found it difficult to concentrate.**
7	There were moments when I was so immersed with my client's experience that I lost a sense of time and space.
8	I was able to put aside my own demands and worries to be with my client.
9	**I felt distant or disconnected from my client.**
10	I felt a sense of deep appreciation and respect for my client as a person.
11	I felt alert and attuned to the nuances and subtleties of my client's experience.
12	I was fully in the moment in this session.
13	**I felt impatient or critical.**
14	My responses were guided by the feelings, words, images, or intuitions that emerged in me from my experience of being with my client.
15	**I couldn't wait for the session to be over.**
16	**There were moments when my outward response to my client was different from the way I felt inside.**
17	I felt fully immersed with my client's experience and yet still centred within myself.
18	**My thoughts sometimes drifted away from what was happening in the moment.**
19	I felt in synchronicity with my client in such a way that allowed me to sense what he/she was experiencing.
20	I felt genuinely interested in my client's experience.
21	**I felt a distance or emotional barrier between my client and myself.**

Note: See the discussion on p. 215 for a description of scoring the items in Table 14.1.

Key messages from therapeutic presence research are therefore the following:

- Therapeutic presence relates to positive therapeutic alliance.
- Clients' perception of their therapists' presence is essential for a positive process and outcome.
- Therapeutic presence underlies Rogers' relationship conditions in general, and empathy in particular.

Practices to cultivate and sustain therapeutic presence

While presence is available to all of us, therapists' ability to access and sustain presence with a client is dependent on their skillfulness in self and other awareness as well as in relational connection. This requires inner training, ongoing practice and a commitment to continued growth and engaging in healthy relationships. Presence

can be cultivated through enhancing qualities of presence (that is, through pausing, clearing a space, grounding and self-care), as well as by working with or removing the obstacles (that is, busyness, technological demands, anxiety, unresolved issues and distractions) that can interfere with being present. Mindfulness, which is a way of enhancing attention and awareness of the present moment, is also a helpful way of cultivating therapeutic presence (Gehart & McCollum, 2008; Geller & Greenberg, 2012; McCollum & Gehart, 2010).

Below are some practical ways by which to enhance a sense of presence before a therapy day, before a session or in your own life. More experiential and mindfulness-based practices for cultivating therapeutic presence can be found in Chapter 12 of Geller and Greenberg (2012).

Pause

If there was only one way in which you could cultivate presence, it would be to pause. Taking a moment to pause is essential in slowing down enough to notice what we are experiencing or what is blocking our ability to be fully here with ourselves or with someone else. Frequent pauses throughout the day, accompanied by intentional and conscious breathing, can help to slow down our internal busyness and create a deeper awareness of our experience.

Another way to include pausing to enhance awareness and presence is to integrate a daily 'slowing down' practice into your life. Take any activity (that is, walking to the office or class, washing the dishes) and slow it down to half its normal pace, and you will begin to notice more of the subtle aspects of that experience. Pausing and taking a breath at a regular interval every time you see a common sight (that is, a stop sign, or when reaching for the door knob to open your door), will also create a space for presence to begin to emerge.

Breathing deeply into the moment

Another way to invite presence is to deepen and slow the breath. Taking longer and slower breaths allows for a calming of the nervous system by activating the parasympathetic nervous system, and hence can evoke a healthier environment in the body for presence to emerge. One way to begin this exploration is to start with our own experience and explore whether attuning and slowing our rhythm of respiration can help to evoke a calmer and more alert and attuned state of being in the moment. Try this breath awareness exercise in a relaxed yet upright posture:

- First, take a few breaths, counting to three on the in-breath, and four on the out-breath.
- Now lengthen the time of the inhalation and exhalation, for example inhaling for 5 seconds, pausing briefly and exhaling for slightly longer than the inhalation (that is, perhaps 8 seconds).

- Allow yourself to visualize your breath becoming deeper, slower and more relaxed, and continue the exercise for 5 minutes.
- Open your eyes and become aware of how you are feeling in this moment.

Ritual to open and close your therapy day

Having a simple gesture or activity to open to presence at the beginning of a therapy day, as well as to release any residual stress or emotions at the end of therapy day, can be helpful. This could include taking a moment to pause in your office and state your intention to be as present as possible to your clients. This could also be reflected in feeling your feet on the ground and connecting to your breath. When intending to release any residual stress or emotion, visualize it melting down through your body and into the ground through your feet. A ritual can also be a physical act of opening yourself up to presence, such as engaging in a yoga posture such as tree posture, lighting a candle (and extinguishing it at the end of the day), playing a simple rhythm on an instrument or visualizing clearing a space inside with the intention to become present. Choose something that works for you and that reflects bringing yourself fully to the moment.

Taking a few moments on a daily basis to engage in a presence ritual can help you begin to familiarize yourself with the experience of presence and optimize the conditions for presence to arise.

Clearing a space

Clearing a space inside involves putting aside one's own needs, concerns, issues and agenda in order to be open and accessible to the client and the depth of their experience, without assumptions or presuppositions (Geller & Greenberg, 2012; Gendlin, 1978, 1996). It is a conscious and intentional practice that is helpful before starting the day, for a few moments before each session or perhaps after a particularly difficult session:

- Sit or lie down in a comfortable position with your eyes soft or closed.
- Become aware of the rhythm of your inhalation and exhalation.
- Begin by asking yourself 'what is between me and feeling fully present and at ease in myself right now?' and wait to see what issues emerge. Spend a moment with each issue that may arise until you intuitively focus on one particular issue.
- Bring awareness of how you carry that issue in your body; notice the physical sensations associated with the issue and just name them (tightness in the jaw, butterflies in the stomach, a knot in the stomach chest, and so on).
- Ask yourself for the intuitive feel or felt sense of the entire issue. Find words – such as frightened, scared, confused, frustrated – or an image for the feel or sense of the whole issue.
- Now visualize placing that issue in a box or on a shelf, putting the whole sense of that issue aside (or you can use other images such as floating the issue away down a river).

- Continue this process until all the issues have been named, acknowledged, felt and temporarily put aside.
- After spending a few moments noticing and releasing barriers to presence, check inside to see if there is a background sense of presence or a cleared space inside.
- Notice what that feels like and rest for a moment in that sense of presence.

Centring and grounding

Generating a sense of centredness helps to access a steadiness within one's self while opening up to the fullness of the other's suffering. Being centred, much like being grounded, is focused in the body (Geller & Greenberg, 2012). Finding a sense of centre and ground can help to maintain equanimity during the potential discomfort of opening fully to the clients' emotional pain and experience. The following exercises can help support the experience of grounding and centring.

- Stand with your feet parallel to each other, firmly on the ground.
- Gently close your eyes and breathe right into the centre of your body.
- Bring your awareness to your feet, feeling the point of contact where your feet meet the ground.
- Rock your feet gently backwards and forwards and from side to side to establish a grounded and centred place to rest in.
- Now hold your spine upright and aligned, and imagine a piece of string at the top of your head being pulled upwards from above you. Feel your feet firmly planted on the ground and your head upright and aligned with the rest of your body.
- Now bring your awareness to your centre of gravity, such as the centre of your pelvis. Rest in that centredness for a few minutes, breathing right into and from the center of your body.

Grounding: tree meditation

- Pause, soften your eyes and connect to your breath.
- As you inhale, imagine the clean fresh air filling your whole body. As you exhale, imagine stress and tension dropping away through the soles of your feet.
- Now invite your awareness to the point of contact where the soles of your feet meet the ground.
- Visualize roots growing from underneath your feet (or the base of your spinal cord if your are sitting down). Visualize these roots burrowing deeper into the ground, beneath the floor, through layers of soil and bedrock, and pushing deeply into the earth.
- Bring your awareness to your body, imagining your legs and body as the trunk of the tree.
- Visualize your arms and head like the branches of the tree, knowing that even though they sway and move in the wind and changing weather, there remains a solidity and unwavering grounding in the feet and their connection deep to the earth.

The following are two other images that can support this posture. The first is to visualize the legs and spine like a pole planted firmly into the ground, imagining the whirlwind of experience moving around you yet not touching the firmness of the pole, which is centred and strong in its contact with the ground. The second is to imagine yourself as a mountain, standing steady at the base, unwavering, aware of the turbulent changes in the weather, yet feeling the stability, grounding and strength of the unwavering mountain.

Box 14.3

Cultivating presence before seeing a client

To aid the process of cultivating presence, use the helpful acronym 'PRESENCE' (Geller & Greenberg, 2012). Spending 5 minutes prior to a session to walk internally through PRESENCE can help you prepare yourself and provide an environment for the conditions for presence to emerge. A PRESENCE moment involves the following eight steps:

- ***P****ause*: take a moment to stop from what you are doing.
- ***R****elax* into this moment by taking a deep breath.
- ***E****mpty* yourself of judgements, thoughts, distractions, agendas and preconceptions.
- ***S****ense* your inner body, bring awareness to your physical and emotional body.
- ***E****xpand* your sensory awareness outwards (seeing, listening, touching and sensing what is *around* you).
- ***N****otice* what is true in this moment; notice the relationship between what is within you (the internal environment) and around you (the external environment).
- ***C****entre* and ground (in yourself and your body).
- ***E****xtend* and make contact (with client, or other).

Conclusion

Therapeutic presence involves therapists' being fully in the moment with their clients, with the intent or purpose of being in the service of a healing process. Research has suggested that presence is essential to effective therapy as well as a preliminary step to Rogers' relationship conditions.

The healing potential of therapeutic presence is enormous, but in today's busy and technology-driven life it is very challenging to develop and sustain. Hence, training one's self to be present in life, to work through the obstacles to intimacy and to relational connection, and to sustain a high level of self and relational care is necessary to cultivate this essential therapeutic quality.

Points for reflection

- How do you practise presence in your own life?
- What brief practices can you engage in between sessions that will help to cultivate and sustain your presence?
- What are some of your major challenges or obstacles to being present both within yourself and with others?

Key readings

- Geller, S. M. (2012). *Cultivating presence: Mindfulness practices for opening to the moment*. Available from www.sharigeller.ca/cd.php.

For guided audio practices using mindfulness and music to cultivate presence.

- Geller, S. M., & Greenberg, L. (2012). *Therapeutic presence: A mindful approach to effective therapy*. Washington, DC: American Psychological Association.

Contains a summary of the research on therapeutic presence as well as practical applications for cultivating presence.

- Hick, S. F., & Bien, T. (2008). *Mindfulness and the therapeutic relationship*. New York: Guildford Press.

An edited book including numerous readings from different theorists on mindfulness and how it relates to the development of a positive therapeutic relationship.

- Senge, P., Scharmer, C. O., Jaworski, J., & Flowers, B. S. (2004). *Presence: Human purpose and the field of the future*. New York: Doubleday.

Information for discovering the relationship between presence and organizations.

- Siegel, D. J. (2010). *Mindsight: The new science of personal transformation.* New York: Bantam Books.

A text that explores the neurophysiological aspects of presence.

- www.sharigeller.ca

The publications page gives access to a collection of articles on therapeutic presence, including a measure of therapeutic presence.

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Note

The author and publisher would like to thank Taylor & Francis Group, LLC. (http://www.tandfonline.com) for their permission to reproduce Figure 14.1, *A Model of Therapist Presence in the Therapeutic Relationship* (Geller, S.M., & Greenberg, L.S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapeutic encounter. *Person-Centered and Experiential Psychotherapies*, *1*, page 76).

15
Working with groups

PETER F. SCHMID AND MAUREEN O'HARA

This chapter discusses:

- The historical development of and the centrality of group work for psychotherapy and counselling from a person-centred perspective
- The 'therapeutic primacy' of the group
- The person-centred group process and facilitation
- The need for a perspective of change beyond the individual

Thinking about therapy does not mean thinking only about one-to-one relationships – on the contrary: the foundations of person-centred therapy would be incomplete without considering the importance of group processes, both in everyday life and in therapy. From the beginning and in much of life, human life takes place in groups. The group is the primary social fact, and because it is the interface of person and society, this also suggests a 'therapeutic primacy' of the group.

'In the beginning there was the group, in the end the individual.' This statement by Jacob Levi Moreno (1959, p. 9), the founder of psychodrama, is also true for the person-centred approach. In terms of both content and history, it can be shown (Schmid, 1994, 1996b) that – although developed as a procedure for counselling individuals – the person-centred approach came into being in groups.

At least as early as the Hawthorne studies in the 1920s, we knew that groups have enormous power to change human behaviour (Roethlisberger & Dickson, 1939). These studies and the work on field theory by Kurt Lewin in the 1940s (which Rogers encountered mostly through contact with Lewin's graduate students through their work at the National Training Laboratories) had a great

influence on Carl Rogers' thinking. For Rogers (1970, p. 9), the group was 'probably the most potent social invention of the century'. And indeed, the person-centred approach has, from the very outset, been a relational approach, a social approach, a group approach. As Wexler and Rice (1974, p. 313) pointed out:

> since its beginnings, Client-Centred Therapy has also sought wider spheres of influence, beyond the individual, both in attempting to explore the relevance of its ideas in contexts broader than traditional dyadic therapy and in seeking to apply its approach to wider social milieus.

In Chapter 32, O'Hara explores the social transformation agenda at the core of Rogers' work as he sought w0ays of putting person-centred principles to work in organizations and groups as early as the 1930s and 40s.

In Chapter 5, the intrinsic and mutual connection between person-centred personality and group theory regarding individual development and mutual encounter is described, and the group as a primary social fact and as the interface of person and society is sketched. The application of these methods as praxis for cultural leadership is then discussed in Chapter 32.

History: the group as an essential factor of the person-centred approach

Historically, client-centred therapy may have been described and developed, at least theoretically, for use largely in individual therapy, but in actual practice and from the very beginning, it incorporated ideas that originated in group experiences, ideas that, in turn, influenced theory. On a closer examination of the history of person-centred therapy, a history inseparable from Carl Rogers' personal stages of learning, it is Rogers' own learning experiences in his relational groups – family, church and university – and his references to his own experiences in these groups that are of initial significance. He lived, learned, taught and worked in groups. Even in his first publication, an article on the World Student Christian Federation Conference in Beijing, Rogers (1922) voiced his fascination with the group experience.

By his own account, Rogers had already begun in 1945 to work with students in groups as a professor at the University of Chicago. His staff groups played an increasingly important role. It was in these staff groups that the theoretical ideas were discussed and further developed based on actual experiences. Furthermore, from the very beginning, the approaches that were developed for person-centred training were set in groups. In 1947, Rogers had already developed a group-centred model to train counsellors for war veterans. Much later, he said about this period: 'They have all been encounter groups, long before the term was coined' (Rogers, 1973, p. 39).

In 1947, Rogers published his first article devoted, even in its title, to the group: 'Effective principles for dealing with individual and group tensions and dissatisfactions'. In a 1948 article entitled 'Some implications of client-centred counselling for

college personnel work', Rogers also wrote extensively about group work and group therapy, touching on many of what later became his key principles, such as trust in the group, which he saw as an organism in its own right. In his 1951 book, Rogers included a chapter by Hobbs (1951) about 'group-centred psychotherapy', and Gordon's research in the same book focused on 'group-centred leadership' (Bowen, Miller, Rogers, & Wood, 1979; Gordon, 1951).

From 1964 onwards, after Rogers' university career and during the height of interest in encounter groups in the 1960s and 70s, Rogers got heavily involved in group work. His Academy Award-winning film *Journey into Self* (Rogers & McGaw, 1968) and his book *On Encounter Groups* (Rogers, 1970) played an important part in the recognition of group work as an important factor in self-development, counselling and psychotherapy. From 1973, he worked with, among others, his daughter Natalie, Maureen O'Hara and John K. Wood in large group workshops, and became engaged in intercultural and peace work (Bowen et al., 1979; O'Hara & Wood, 1984; Rogers, 1977, 1980, 1983; Rogers & Rosenberg, 1977; Wood, 1988).

The 'La Jolla Program', a program characterized by its alternation of large and small group experience (from 1967 onwards), became *the* model of person-centred facilitator training (Coulson, Land, & Meador, 1977). Although those workshops and programmes were not explicitly therapy, they contributed enormously to the growing political self-understanding of person-centred therapy. Quite early on, small and large group workshops were held all over the world and further theory was developed. Major contributions to theory stem from Bowen et al. (1979), Braaten (1995), O'Hara (1997), O'Hara and Wood (1984, 2004), Pagès (1968), Schmid (1994, 1996a, 1996b, 1998, 2000, 2001) and Wood (1988); a reader was published by Lago and MacMillan (1999), a book on group counselling by Tudor (1999) and a Japanese book on facilitation of encounter groups by Noyima (2000).

The work with 'intensive groups', as Rogers liked to call the encounter groups, contributed significantly to the development of the person-centred approach as such. The reciprocity of help Rogers often experienced in these groups exceeded such experiences in individual therapy.

The conceptualization of the group 'leader' as a facilitator affected the conceptualization of the person-centred therapist in one-to-one therapy. The work with, and within, groups was instrumental in helping to understand human beings within relationships and interpersonal relationships in general. The definition of the 'fully functioning person', not simply as an individualistic self, but as a self within society, and the social and, by extension, political dimension of the person-centred approach, also originate largely in experiences from small and large groups. Finally, the highly democratic, egalitarian valuing of each person's contribution as equal to that of the facilitator (contrasting with other more expert-centred orientations) affirms the personal power of each participant.

These points justify Raskin's (1986a, p. 281) comment that 'the encounter group was and remains one of the most outstanding forms of expression for the person-centred approach'. (For more details, see Schmid, 1994, 1996b; overviews of the

history can be found in Barrett-Lennard, 1998; Raskin, 1986a, 1986b; Schmid, 1996a.) Large group workshops following the model of the La Jolla Program, with its interplay of small and large groups experiences, self-organized and facilitated groups, are still convened in several parts of the world (a description can be found in Schmid, 1996b), including Austria, Hungary, Germany, Oregon in the USA, Brazil and Argentina, and have been established as a routine pre-programme to the World Association of Person Centered and Experiential Psychotherapy and Counselling conferences.

Therapy theory: the 'therapeutic primacy' of the group

One of the consequences of understanding the group as a primary fact in the life of people and its essential contribution to the development of person-centred therapy is to understand that the person-centred approach is fundamentally a group approach and person-centred therapy is fundamentally group therapy (Schmid, 1994). We suggest putting it even more pointedly: person-centred therapy is, by its very nature, not a process of individual therapy that just happens to be applicable to groups. Rather, it is, in its essence, a social approach, an approach relating to groups, and thus a 'group approach' that also happens to be applicable to relationships between two people (dyads, pairs) as special types of groups. This turns the traditional view upside down: person-centred therapy involving two people, so-called 'individual therapy', can be defined as a special type of group event, a 'group of two'.

This implies in our view that the group should be considered to be the initial point of entry into therapy. In other words, unless other reasons make another decision obviously preferable, the group is the setting of choice for the human being to come to terms with him- or herself. Problems stemming from interpersonal relationships can be understood relationally and dealt with in interpersonal relationships. Once such a relational view is grasped, it follows that, by recreating the context from which many psychological problems originate, the group provides the richest environment for addressing them successfully. Group psychotherapy brings the problems back to the point where they belong.

The relational perspective advanced in this chapter and Chapter 5, in which the notion of 'individual counselling' becomes reframed as counselling within a group of two, opens up the question of whether the current focus on so-called individual counselling might be reconsidered as the customary entry point for most people seeking counselling, and the group reclaimed as a rich and potent setting for transformational growth. Following this perspective, a therapist recommending somebody to psychotherapy should first consider the advantages of a group (for a discussion of the pair as a special form of group and the implications for therapy, see Schmid, 1996a).

One of the principle advantages of a group is that it permits a lived-experience of the plurality and complexity of life. The rich diversity that is human existence

comes alive in the group. In individual therapy, the client's multiple relationships (beyond the one to the therapist) can be addressed only indirectly. The actual experience (and attempts to try something new) happens outside, in between the meetings. In group therapy, this is possible in the group itself, where the relationships among the group members offer a broad and varied field of experience and possibility to try something new, receive immediate feedback and reflect upon it in real time. These learning experiences can often be transferred immediately to other groups and relationships in the client's life.

In group work, the whole group is 'the therapist'. Each member can be a facilitator for another member, which increases the possibilities of receiving feedback and learning from each other. The client encounters multiple viewpoints and multiple values systems, unlike in individual therapy where they encounter only that of the therapist, thereby facilitating their discovery of their own values and perspectives. Self-development 'in the company of others' (Merry, 1988, p. 22) enriches empathy. To find 'fellow sufferers' and to find oneself 'not alone' can be an enormous relief and greatly help one to accept oneself. There are also 'spectator' effects as people witness others profiting from openness and risk-taking. But more than this, it usually encourages people to similarly dare to open up and take a risk.

That everybody can be therapeutic for somebody else brings home the fact that we are all fundamentally of value and are capable – a realization that is of enormous potential for therapy and personality development. Being able to help another intensifies self-esteem and can be therapeutic in itself (Schwartz & Sendor, 1987). Furthermore, peer-to-peer interaction has a different quality from client–therapist interactions. Being understood by a non-professional feels different from being understood by somebody whose job it is to do so. Also, confrontation, even by the therapist, is somehow easier to accept and process because there are probably other members who support the views or behaviours of a particular member.

Beyond this, group therapy has an anticipatory function. Representing society in microcosm, the group is the arena where current and even future developments, problems and trends in society can be observed and investigated, and new understanding developed. New ways of dealing with social shifts then can be tested as they emerge. Thus, the group is not only of psychological and therapeutic value, but also has enormous potential impact on response to societal changes. At the height of social progress towards racial equality in the USA, for instance, black and white group members could safely explore the ways in which their relationships were distorted by the past history of racism, and could in the group, supported by other members, experiment with more authentic and respectful ways of relating. In place of the stereotypical attitudes of white superiority that had plagued America since the days of slavery, new social patterns were able to emerge (see Box 15.1 below).

The shift of perspective from 'therapy of an individual by an individual' to 'therapy of the person in a group' (to really be *person*-centred means to address somebody in their substantial and their relational dimension; see Chapter 5) opens up the

possibility of seeing person-centred groups as a locus of healing within the larger society (for a further discussion of the implications of this for sociotherapy, see Schmid, 1996a, 2002).

Finally, there is a dimension of group experience that when present offers access to expanded levels of awareness. O'Hara and Wood (1984, 2004) have described the extraordinary moments in group life when the 'group mind' or the collective consciousness of the group as an entity becomes accessible to its members. In these moments, people are often capable of reconciling complexities that had seemed intractable just minutes before – when we recognize that what we usually see as fragmented is really whole. Towards the end of his life, Rogers was becoming interested in the work of physicist David Bohm, acknowledging the similarities between person-centred approach experiences in large groups and Bohm's discussions of 'implicate order' (Bohm, 1983; Bohm & Edwards, 1991).

Group process: The participants are the process

To understand what goes on in a person-centred group, several distinct levels of process must be kept in mind at the same time:

- What is going on within the subjective experience of each individual?
- What is going on between individuals on the interpersonal level?
- What is going on at the level of the group as an entity?
- What are the externalities that provide the context?

As discussed throughout this volume, central to the person-centred approach is a basic trust in what Rogers termed a 'formative tendency' in nature, of which the 'actualizing tendency' in human beings is a manifestation (see Chapter 6). He observed that when core relational conditions of genuineness, unconditional regard and empathy (discussed in more detail in Chapter 2 and in other chapters in Part II) characterize person-to-person interactions, whether in a dyadic group or a group of up to a thousand, this actualizing tendency can be counted on to move both individuals and groups in the direction of growth and healing (Rogers, 1986). In individual therapy, it is the therapist who is primarily responsible for creating these conditions. In a group, the facilitator is responsible for setting up important boundary conditions such as time of meeting, place, duration and membership, and makes other important contributions that we discuss below, but the responsibility for the process of the group is distributed among all the members, who jointly contribute to the creation of an enabling climate of trust, acceptance and caring. In later years, Rogers described the concept of 'presence' as a basic facilitative condition (see Chapters 5 and 14).

Rogers and others (Bowen et al., 1979; Natiello, 1987; O'Hara & Wood, 1984, 2004; Schmid, 1996a; Wood, 1984) have described the process of person-centred group development. Rogers (1970) identified 15 patterns in the group process. These do not necessarily occur exactly in sequence, but some version of

this unfolding process is visible in most person-centred groups. A detailed description of these phases of the group's life can be found in Rogers' *On Encounter Groups* (1970) and corresponds closely to the stages of group development described in the group dynamics literature (Bradford, Gibb, & Benne, 1964; see also O'Hara & Wood, 1984; for an overview of person-centred analyses on group stages, see Schmid, 1996a).

As the group unfolds over a day, an intensive weekend or several weeks, in principle the same shifts occur. In the early stages of a group, there often is a period of chaotic, incoherent and disconnected communications. Distrust and reticence are high. At the beginning, for most people the sense of 'we' exists only as a theoretical potentiality – a hoped-for reality, perhaps to be realized, perhaps not. For some, the idea of 'we' is quite threatening as they fear their individual 'self' might not have a place in a collective 'we'. They are more concerned with their sense of individual reality and their place in the ongoing events. In a group made up of warring factions in Northern Ireland, recorded in the film *The Steel Shutter*, for instance, members' mutual animosity made them at first closed to the idea of a 'we with people from the other side' (McGaw & McGaw, 1973). In recent work in South Africa and Guatemala, Adam Kahane (2004) has observed the same initial reluctance.

As the first tentative communications are heard, accepted and responded to, there is a deepening of expression of feelings and self-disclosure, which in turn provokes even more open sharing. Early on, most communications are directed to the facilitators, but as the facilitators make it clear that they are not there to direct or fix anything, but to participate, people gradually begin to take risks, to test out their freedom and to allow themselves to be authentic with each other. They may express anger at another member, sadness about a loss or irritation at the process. There is less talking 'about' the past or abstractions and more direct experience of immediate, here-and-now experience.

At the same time, people begin to attune to each other in deeply empathic ways. They listen more deeply and allow themselves to be moved by each other's humanity. They find themselves moved in powerful ways by the stories of the others and, as this happens, experience becomes more vivid and more intense. As Natalie Rogers has said, the group comes to 'listen to the music, not just the words' (personal communication, 2005). Gradually, as people express more and more of their individual experience, the essential 'we' – the sense of a greater entity to which the individual participants are contributing – emerges and begins to make its presence felt in the consciousness of everyone. In the immediacy of the present experience, a sense of what Levi (2005) has called 'group magic' becomes palpable to almost all. It is in this state that the truly transformative work occurs.

The shift to a transformative state is often sudden. It cannot be produced, hurried, engineered. It is a shift that happens in the group field beyond direct manipulation by any individual. Often these expansive moments occur in the silence following some expressed deep feeling or compelling story (Box 15.1).

Box 15.1

Transforming antagonism through authentic expression

In one group, after a period of chaotic, awkward and inauthentic conversation, an interaction between an African-American man and a white South African man became heated. They were (like many people who had talked before them) talking past each other, not listening but expressing themselves in indirect, sarcastic jibes. Suddenly, the African-American man exploded with frustration. He poured out his pain about the policy of apartheid and expressed his rage and distrust of the white South African man. The group listened in stunned silence. After he had finished, the South African member responded, just as forcefully and with equal frustration. He was an anti-apartheid activist who had left South Africa in fear for his life. He was terrified that his family was in danger from both black and white South Africans.

The two men looked silently into each others' eyes for a long time. As they did so, the climate of the group shifted and a new state of being together emerged. Where there had been separateness there was now a sense of alignment and attunement, where there had been a sense of despair there was now hope, and where there had been opponents there was now solidarity. As one member observed afterwards, 'At that moment I could see that we are all really one – there is no separation or disconnections except those we construct. When we meet in this way, I can see my way through. I can know universes.'

It is not always conflict that marks the phase shifts in a group. It might just as well be a moment of selfless giving, deep empathy, uncontrolled laughter of the kind that make one's sides ache, or a simple silence at the right time. Whether in a group billed as a person-centred approach group, or some other dialogical group process, what these moments have in common is that members surrender to the moment – fully aware of themselves as unique individuals, but fully engaged and attuned to the present moment. It is a point beyond dualism, and what appear to be intractable contradictions one moment seem solvable the next. O'Hara and Wood (2004, p. 65) have called these groups 'conscious groups'. John Wood (1988, p. 42) put it in a nutshell: the members 'are not "material" for the therapeutic process; they are the process'.

Group facilitation: the art of being co-player *and* counterpart

Understanding person-centred group facilitation presents us with a paradox. The most generative aspects of group processes occur among the members of the group and are not produced by the facilitators. Thus, we do not talk about 'group leaders'

or 'trainers' but 'group facilitators' who foster the therapeutic, growth-promoting process of the group. The group itself takes the function of 'leading', and different participants take a leading role at different stages or for different tasks in the interaction of the evolving group process. In contrast to other conceptions, such as guiding, steering, interpreting, inducing exercises and group games, staying absent or taking the role of an agent provocateur, the person-centred approach emphasizes the personal qualities and capacities of the facilitator, their ways of being, over the use of technical expertise. The primary task of group facilitators is – according to the image of the human being as a person (see Chapter 5) – to be an active, involved, committed participant in the group who demonstrates trust in the actualizing tendency, in the emergent process and in the individual persons in the group. At the same time, person-centred facilitation is a highly complex and multilayered responsibility, requiring a level of self-mastery and psychological maturity, personal and interpersonal competence and technical expertise achieved through long and disciplined experience. (For details on group facilitation, see C. Rogers, 1970; N. Rogers, 2011; Schmid, 1996a.)

The facilitator must be able to demonstrate the core conditions in their interactions with individual participants in ways that are appropriate to the group setting – which are different from the individual counselling session – *and* in their interactions with the group as a whole. They must know, for instance, how to listen empathically to an individual who is speaking, but also to listen empathically to the group as an entity. For example, if one person is talking a great deal and others in the group are becoming bored or even hostile, the facilitator sometimes has to make a choice between continuing to attend deeply to one individual in favour of making a comment about the obvious discomfort of someone else. In a group, the timing of such a choice is very important. Not enough focus on individuals at first in favour of attention to the group can lead to an environment where people feel devalued or unsafe. Too much focus on the individuals later in the group can lead to the stifling of vitality and dependence. Too much self-expression by the facilitator too early can have an inhibitory effect on a group; too much too late and it can shift the focus of attention back to the facilitator and away from the emerging group consciousness.

Facilitators need to be co-players, inter-actors, co-participants; they need to be counterparts, persons to 'en-counter', 'Others' for the participants (see Chapter 5 and Schmid & Mearns, 2006, for the concept of resonance). They see their task as using their power to empower the group and the participants. Coghlan and McIlduff (1990) have pointed to the importance of facilitators learning how to use their personal power effectively. Making assessments moment by moment of when and how to intervene requires understanding of the dynamics operational at all four levels, and above all it requires preparation.

Rogers and both of us have stressed the importance for facilitators co-leading person-centred group encounters of preparing psychologically as a team and carefully reflecting upon the ongoing process together. It has been our observation that groups have a remarkable capacity to pick up what is going on in the subgroup that is the 'staff'. If there is friction among facilitators, for instance, this will be noticed and

reacted to by group members, and if an individual leader is troubled in some way, this can have significant effects on group members, even if the facilitators do not disclose this. Such phenomena should not surprise us when we consider that the group is the site of human evolution. Before we had verbal language, we knew, as a matter of survival, how to read the signs expressed in the non-linguistic patterns of group life. In particular, all group primates know to stay very aware of what the dominant members are doing, or risk losing their place in the group (Waal, 1986). The more the facilitators can become open to and congruent with each other, achieving a high level of group attunement and alignment, the more their presence will be experienced as providing basic safety for participants and will provide a model for group participation. (For a more detailed discussion, see Bowen et al., 1979; O'Hara & Wood, 1984, 2004; Rogers, 1980).

The success of person-centred groups should not blind us to their potential negative outcomes. As Rogers (1970) has described, the group can be a frightening place. The unstructured group provides a setting where anxiety is generated, and the various responses to that can be distressing to participants. Anger, rejection, ongoing self-defence, scapegoating, boredom, blaming, shaming and putting pressure on others can go on in a group, especially with a poorly trained facilitator. It is the responsibility of all participants, the facilitators included, to meet these challenges, and particularly to deal carefully with power issues. The negative aspects of groups in the early unstructured group experiments resulted in their disfavour within the business setting and propelled innovations in the direction of more facilitator structuring, which provided greater psychological security, more reliable task-oriented outcomes and less distress (Alban & Scherer, 2005).

The chance for change beyond individual change

In the ongoing development of person-centred therapy as a dialogic therapy (see Chapter 5), the group plays a vital role in changing the perspective from the individual to the person in context and contributes to recognizing the necessity for change beyond individual change. In broadening the view in this way, it may lead to an awareness of the social and political dimensions of psychotherapy.

From the beginning, the group has played a central role in person-centred therapy training. Training groups provide not only a context for learning skills, but also a chance and challenge to experience the group's potential and potency for developing the trainee's personality and self-understanding as a therapist. In our view, the group provides the trainee with an unequalled experiential base within which to learn to trust the group as a therapeutic option for both individual and social issues.

It is more than 65 years since Rogers' earliest exploration of the group as a site for psychological growth. As already mentioned, the work with encounter groups provided a basis for the political, societal and peace work (discussed in Chapter 32). Among other applications, person-centred group theory and experiences have been providing a basis for psychodrama, student and learning groups, expressive arts

therapy and work with children, supervision (see Chapters 14 and 30), several kinds of person-centred business training in groups, training groups of all kinds and considerations on person-centred leadership and teamwork.

Points for reflection

- Reflect upon your positive and negative experiences in groups. What did you like and what dislike? What were you afraid of, and what hopes did you have for working in or with groups?
- Can you identify your personally preferred style of leadership and how this is in line with person-centred principles?
- Can you recall experiences when you felt that groups had a societal impact, and what were these?

Key readings

Besides Rogers' book on groups John Wood's book provides an inside view of the connection between individual, encounter group and large group work:

- Rogers, C. R. (1970). *On encounter groups*. New York: Harper & Row.
- Wood, J. K. (2008). *Carl Rogers' person-centered approach: Toward an understanding of its implications*. Ross-on-Wye: PCCS Books.

As well as reading, the best way to learn about person-centred groups is to participate in one. Several sources on the internet provide information about small and large group events (see, for example, www.pce-world.org; http://austriaprogram.pfs-online.at, www.pca-online.net).

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16

Person-centred expressive arts therapy: connecting body, mind and spirit

NATALIE ROGERS

This chapter discusses:

- The expansion of Carl Rogers's theory of creativity to include the expressive arts
- The transformative ways in which person-centred expressive arts foster personal authenticity, self-insight and healing
- How person-centred expressive arts therapy differs from the analytic or medical model of art therapy used for diagnosis and treatment
- The Creative Connection, an expressive arts process that interweaves movement, art, sound and writing in sequence to tap into the well of unconscious imagery
- The humanistic principles involved and applications of person-centred expressive arts therapy
- Ways of bringing non-verbal forms of self-expression and communication into the client–counsellor relationship and group facilitation
- Using the creative process to foster world understanding and peace

Expanding Carl Rogers's theory of creativity to include expressive arts

Are you intellectually curious? Open to new evidence? Are you able to open your heart as well as your mind to twenty-first century neurological evidence of the

mind–body–spirit connection while practising the time-honoured, proven concepts and values of the person-centred approach? As philosopher and theologian Howard Thurman has put it:

> *The deepest hunger of the human spirit is to be known.*

In this chapter, I hope to show you that expanding Carl Rogers's theory of creativity to include *experiencing* the creative process advances his ideas and, in practice, enables individuals to fully connect body, mind and emotions for the development of the highest spiritual self. The expressive arts are an important expansion of the person-centred approach because, simply put, *we cannot integrate all aspects of self without involving all aspects of self*. We reawaken our creativity by engaging in the process of creativity, which leads to conscious evolution and social change. Practitioners of the person-centred approach in the twenty-first century must integrate this holistic, healing approach into their work.

In his book *On Becoming a Person* (1961), my father, Carl Rogers, discusses the desperate social need for creative individuals and puts forth a theory of creativity:

> The mainspring of creativity appears to be the same tendency which we discover so deeply as the curative force in psychotherapy – *man's tendency to actualize himself, to become his potentialities*. By this I mean the directional trend which is evident in all organic human life – the urge to expand, extend, develop, mature – the tendency to express and activate all the capacities of the organism, or the self. (p. 351, original emphasis)

Rogers (1961) intended that the person-centred approach should not become some sterile dogma or 'method'. As the chapters in this Handbook book make clear, his values, philosophy and ways of practising psychotherapy are profound. The avenues by which we can manifest the self are many.

Having learned the person-centred 'way of being' partly by osmosis as his daughter and partly by working with Carl in large encounter groups over many years, I came to find my own way of being with a client and with groups using all of the arts to discover our immense capacity for creativity. There was no name for this in 1960. Now there is a recognized field of expressive arts therapy. My contribution to the field of expressive arts has been to bring to it the basic values and methods of the person-centred approach – creating a safe emotional space and empathic listening – while using the arts in psychotherapy and groups (N. Rogers, 1993, 2011). Now that expressive arts has proven to be a transformative, healing process, I wish to bring this process into the field of the person-centred approach.

What is person-centred expressive arts therapy?

Expressive arts therapy uses movement, drawing, painting, sculpting, music, writing, sound and improvisation in a supportive, client-centred setting to enable individuals and groups to *experience* and *express* feelings. Any art form that comes from an emotional depth provides a process of self-discovery.

To use the arts expressively means going into our inner realms to discover feelings and to express them without concern about the beauty of the art, the grammar and style of the writing, or the harmonic flow of the sounds. Although interesting and sometimes dramatic products emerge, we leave the aesthetics and the craftsmanship to those who wish to pursue the arts professionally. This is an intermodal approach that emphasizes the healing power of creating art and the use of imagery for self-insight.

Expressive arts therapists are aware that the client's use of movement, sound or visual art will bring forth intuitive yet undiscovered imaginative abilities. Since emotional states are seldom logical, imagery and non-verbal modes of expression provide an alternate path for self-exploration, as well as a new way to communicate with the therapist.

> *Creativity is like freedom: Once you taste it, you cannot live without it. It is a transformative force enhancing self-esteem and self-empowerment.*

When the client uses art, she plunges into the world of emotions. There is another dimension: *release* of pain, fear and grief, as well as *insight* and perspective on the causes of these conditions. Expressive arts therapy ultimately unleashes the free-spirited and joyful aspects of self through learning on many levels: sensory, kinaesthetic, conceptual, emotional and mythic. Clients report that the expressive arts help them go beyond their problems to find a new sense of soul or spirit, and they envision themselves taking constructive action in the world.

Enhancing the therapeutic relationship

Use of the expressive arts enhances the therapeutic relationship in many ways. It helps the client:

- identify and be in touch with feelings;
- release and transform energy;
- explore unconscious material;
- gain insight;
- solve problems;
- discover the spiritual aspects of self.

Using this process is particularly effective with individuals who tend to be highly rational and verbal. Clients often become experts in talking about their problems rather than allowing authentic feelings to well up. Dancing frustration, painting anger or writing a grief poem releases 'negative' emotions and transforms them into pure creative energy. Spontaneous imagery awakens unconscious thoughts and attitudes and brings new insight into one's deeper reality. A collage may show the client various aspects of a practical problem and help solve it or aid decision-making. As defences are shed, a sense of the authentic self emerges.

> *Art is a universal language. When the client shares her personal art, she is opening a window to her soul to me as a therapist. I am in awe as I view the strong images of self-expression that help me comprehend the client's inner world.*

Person-centred versus analytic expressive arts therapy

Humanistic expressive arts therapy differs from the analytic or medical model of art therapy, in which art is often used to diagnose, analyse and 'treat' people. Carl veered away from psychoanalysis and interpretation; so, too, have I rejected analytic and interpretive forms of art and movement therapy. In terms of methodology, this means I follow the client's leads as she discusses her art, movement or writing. We believe in the ability of individuals to find appropriate self-direction *if* the psychological climate is empathic, honest and caring. Of tremendous importance to me is the fact that the person-centred philosophy is the foundation on which my form of expressive arts therapy rests. I base my approach on my deep faith in the innate capacity of each person to reach towards full potential if given a safe, person-centred environment for growth.

The Creative Connection – expanding the person-centred approach

What I call the Creative Connection describes a process through which one art form stimulates and fosters creativity in another. In the early years of my career, I came upon personal discoveries that led to the application of this process in my work as a therapist. I found that when I danced or drew angry or sad feelings in the presence of an empathic, non-judgemental witness, my feelings and perceptions shifted dramatically. And when I drew the images after moving, the art became spontaneous, expressive and revealing. If I followed the art with free writing, I plunged further into guarded feelings and thoughts. Also, I understood that using the arts *in sequence* evokes inner truths with new depth and meaning. Inner healing takes place because of the Creative Connection.

To feel emotionally free to explore in this way, I needed a stimulating, permissive, supportive, non-judgemental environment. That is when I realized that the empathic witness to personal creative exploration is similar to the client-centred therapist. Using the arts as another language brought me even closer to the client's world. The I–thou relationship was enhanced as I listened to clients' self-exploration of their movement, image or sound. Even more amazing was that, in creating the art, the *client's feelings began to shift transformationally*.

Using expressive arts with clients

In therapy, I introduce the possibility of using the expressive arts to the client some time during the first three sessions. I might say:

> I may offer you the opportunity to use movement or art to help you explore your thoughts and feelings. This may give you new information about yourself. I don't use art to diagnose or interpret you. The art and movement processes are available to you as another avenue of self-exploration and healing. (N. Rogers, 1997)

Some people are eager to use the art materials. Others say, 'I can't draw', or 'I'm not a creative person', or 'I've got two left feet and can't dance.' Briefly, I reassure them that it is not a test of their creativity or drawing or dancing ability, but a method of self-discovery. I might say, 'I will make suggestions and encourage you, but the decision is up to you. I will respect it.'

Trusting the client's path

When a client is expressing strong emotion, I often ask, 'Would you like to explore that in colour or movement as well?' The client may say, 'No, I need to talk some more.' If she says, 'Yes,' I ask, 'Would you like to draw, or move, or make sounds?' I follow the client's lead. If a client chooses visual art, I sit silently as an empathic witness. Then I ask her to tell me what the experience was like as she created the piece. We look at it together and I encourage her to describe it and give it meaning. I respond with empathic statements, checking: 'Do I get your real meaning here? Is there more you wish to explore?' (N. Rogers, 1997).

> *One might ask, 'Is offering expressive arts a distraction from the purpose of therapy?' Rather than being a distraction, using the arts helps both the client and the therapist to focus on the emotional or feeling aspect that has been occurring in the verbal dialogue.*

The Creative Connection group process

Applying this process in groups is particularly powerful: it evokes a sense of unity and awareness – a collective healing. I describe and illustrate this as 'collective resonance' in my book *The Creative Connection for Groups* (N. Rogers, 2011, p. 226).

To involve participants deeply in the Creative Connection process, our group participants spend a majority of time within the workshop exploring a sequence of art experiences that lead them into their inner realms. Each step of the way, they express feelings through art. Often we start with some movement, such as moving with the eyes closed and letting the body move with feeling in spontaneous ways. After several minutes, participants silently express themselves with paint, pastels, clay or collage. Visual art comes out of the felt-body experience. The work might be abstract colours splashed on the page with abandon or carefully constructed collages; it doesn't matter. At the point of creation within the workshop, a sacred space emerges through collective, side-by-side inner experiencing. Each person feels safe to be free in his or her style and expression. After the visual work and movement, participants write uninterruptedly for 10 minutes, accessing free associations or stories without censoring or concern about the logic of what emerges.

Finally, the group shares verbally. An empathic listener, a cornerstone of the process, helps participants understand their experiences. This is a time to talk about the meaning of images, contemplate the messages in the colours or flow of the lines, and further explore them in movement or sound. Perhaps the writing calls for a

dramatization. The spiral of activities continually peels off layers of inhibition, dropping the participant into the core of her being where she can open to the universal energy source of vitality and oneness.

> The art product being created and the creator influence each other in a dance of active shaping and letting go. (Hartke, 2011, p. 4)

A stimulating, permissive, non-judgemental environment sparks and renews vibrant, childlike creativity. Participants are often surprised at this wonderful experience, making comments such as, 'I started to paint a tree, but somehow it became an angel.' Or 'I was looking for some specific images in the magazine for a collage, but other pictures jumped out at me and asked to be used.' These spontaneous creations also happen kinaesthetically. One man said, 'I didn't dance, it danced me!'

The healing power of person-centred expressive arts: a personal story

In sharing the following personal episode, I hope you will better understand this method and vicariously experience my process of discovery and growth through movement, art and journal-writing in an environment of acceptance.

The months after my father's death were an emotional rollercoaster for me. The loss felt huge, yet there was also a sense that I had been released. I felt that his passing had opened a psychic door for me as well as having brought great sorrow.

The arts served me well in that that time of mourning:

> The expressive arts are grounded in 'the capacity of the arts to respond to human suffering'. (Levine, 2011)

I spent several weeks with a friend in her cottage on Bolinas Bay painting images that were all dark, tsunami-like and disturbing. Every time I became bored with those black images, I started another painting, which, too, emerged as moody and bleak. The background of the sea helped me touch my subterranean feelings of loss and grief. My friend's encouragement to paint and use art to release and understand my feelings was liberating.

Next, I had to face the daunting task of emptying my parents' home, making decisions about my father's belongings, and responding to the condolences of hundreds of people who loved him. I continued with my artwork, which yielded more relief and self-insight. That year my expressive art creations charted my sense of loss as they opened me to new horizons.

In grief, there may be a window to spiritual realms. Three months after my father's death, I flew to Switzerland to co-facilitate a training group. My colleagues were aware of my loss, and I gratefully felt their love and silent support. My heartache created a heightened sense of connection to people, nature and my dreams. I experienced synchronicities, special messages and remarkable images. One night I was awakened by what seemed to be the beating of many large wings in my room.

The next morning, as I drew the experience as best I could, I felt an exquisite, powerful sense of universal love that was, at the same time, deeply personal, healing and exhilarating. My heart cracked open, leaving me both vulnerable and strong. My mourning softened to a new awareness.

I include these vignettes to illustrate the transformative power of the expressive arts and the importance of the empathic listener in the process. Being with people who allowed me to be in my grief, rather than patting me on the shoulder and telling me everything would be all right, empowered me to explore my loss without fear of being interpreted or misunderstood. I knew that if I had something to say, I would be heard. None of my colleagues tried to tell me what my art meant or gave me advice about how to grieve.

Transcending inner polarities

When I work with groups, we often spend time brainstorming 'our inner polarities' and come up with long lists: love/hate, strength/weakness, close/distant, introvert/extrovert, happy/sad, violent/peaceful, and so on. Although the opposites may appear to be 'good' or 'bad' characteristics, it is not that simple. While some clients may need to acknowledge and accept their shadow, others may need to allow themselves to receive love or have feelings of delight or optimism. This unfolds through the process.

In Jungian terms, the *shadow* is that aspect of the self that is unknown or that lives in the realm of the unconscious. The parts of the self we reject, deny or repress are frequently thought of as destructive or evil impulses; keeping these shadow parts in check drains emotional and physical energy. To know, accept, express and release them in non-hurtful ways is liberating – and is essential for preventing these powerful forces from being acted out in violent forms. I have been present while many clients or group participants have expressed through art fear of death, of going insane, or of staying forever in the deep, dark pit of depression. When given a voice, an image, a sound or a dance, our fears become forces of change. When accepted for exactly what they are, our 'demons' propel us on our road to recovery.

We often relegate our strength, rebelliousness, sensuality, sexuality and willingness to love to the shadow realm of the unconscious. We unknowingly and incorrectly believe that living in the shadow is less dangerous than embracing the light and opening to the wellspring of love, compassion and larger states of consciousness that are available within us. We are so uncomfortable acknowledging our greatness. Readily we accept negative thoughts about ourselves and others, while fending off compliments and expressions of caring, respect and love. As we become aware of the ocean of light within, we develop the capacity to give and receive unconditional love in a universal sense. We accept our own goodness.

When we risk exploring the depths, we find the freedom to soar. Discovering our hidden selves gains us allies: long-lost subpersonalities that complete us. We become whole, energized, compassionate people (Zweig & Abrams, 1991).

Humanistic principles

Since not all psychologists agree with the principles embodied in this chapter, it is important to state them clearly:

- All people have an innate ability to be creative.
- The creative process is healing. The expressive product supplies important messages to the individual. The process of creation is profoundly transformative.
- Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding and insight.
- Feelings of grief, anger, pain, fear, joy and ecstasy are the tunnels through which we must pass to get to the light of self-awareness, understanding and wholeness.
- Our feelings and emotions are energy sources that the expressive arts liberate and transform.
- The expressive arts lead us into the unconscious and to express previously unknown facets of ourselves, which give us new information and awareness.
- Art modes interrelate in what I call the Creative Connection. When we move, it affects how we write or paint. When we write or paint, it affects how we feel and think. During the Creative Connection process, one art form stimulates and nurtures the other, bringing us to an inner core or essence that is our life energy.
- A connection exists between our life force – our inner core or spirit – and the life force of all beings.
- Therefore, we journey inward to discover our wholeness and our relatedness to the outer world. The inner and outer become one.
- It takes a safe, permissive, empathic environment for individuals to have courage to use these creative processes for personal growth and self-empowerment.

There are many discoveries to be made with this work: our boundless spirit and universal soul; the ability to laugh at ourselves; wisdom; the knowledge that every struggle we face is a teacher, if we are open to the lessons it offers.

Applications of person-centred expressive arts therapy

Many psychotherapists, social workers and self-help groups now use the expressive arts as tools for behavioural change. Alcohol treatment centres use these methods to help addicts go beyond recovery to reawaken creativity and find hopeful images for the future. It is my belief that people become addicted to drugs, at least in part, when their creativity is blocked. Expressive arts offer an opportunity to reconnect with innate creative ability.

Victims of sexual abuse with repressed awareness can find healing through the expressive arts, which loosen the grip of denial and foster healing of the deep wounds left by abuse. Hospice workers and counsellors assisting people with grief find these non-verbal methods particularly rewarding. Some corporations are beginning to use the arts to develop teamwork and examine organizational problems and goals in creative, out-of-the-box ways.

Person-centred expressive arts practitioners have written about their experiences using these methods with grieving children, angry adolescents, high school students exploring spirituality, elders celebrating life, people with eating disorders, grief groups, groups of developmentally disabled women, cancer patients, returning veterans and cross-cultural groups (see Chapter 10 in N. Rogers, 2011).

Conclusion: future perspectives

Nothing holds us back from resolving our world dilemmas except the lid we have placed on our creativity. Opening ourselves to the creative force within us allows us to envision all possibilities, stimulating our will and determination to shape a positive future that we anticipate with excitement. Holding the vision is important; we can be pioneers who light the candle.

It is imperative that our educational systems, corporations, political organizations and leaders use the creative process to bring greater peace and understanding in the world. This kind of change begins with individual awareness. Awareness is always the first step – it gives us choices. Rekindling our personal creative expression in person-centred environments will help us regain psychic balance and our basic goodness and wholeness.

Although we can never expect that the peoples of the world will be of one mind – there will always be conflict and controversy – we can hope that, as individuals and communities, we will use our enormous creative powers to discover beneficial solutions to the challenges humanity faces. If we are resolved, as a world community, to settle disagreements peacefully, it can happen. We have all the technological resources and the brainpower to solve our global crises. We need willingness and determination to look for solutions creatively, cooperatively and generously.

Points for reflection

- Does the idea of using spontaneous creative expression for personal growth and insight appeal to you? Or do you find yourself shying away from such an approach?
- If you find yourself shying away from these processes, do you know why? Were you graded on your art? Told you were a klutz when you danced? Do you remember enjoying self-expression as a child? What else might be holding you back? Fear of being judged? Fear of the inner critic? Fear of the unknown?
- Can you imagine yourself getting training in person-centred expressive arts as part of your journey to become a therapist or mental health professional?
- How can the world and the future benefit from the use of the expressive arts individually and in groups?
- What is your vision of the future of the world, and how would you like to impact it?

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Note

This chapter weaves together ideas and direct quotes from three sources: Natalie Rogers' books *The Creative Connection for groups: Person-centered expressive arts for healing and social change* (2011) and *The Creative Connection: Expressive art as healing* (2001), and from Natalie's chapter in *Foundations of expressive arts therapy*, edited by Stephen and Ellen Levine (Jessica Kingsley Publishers, 1988).

17
Integration in person-centred psychotherapies

DAVID J. CAIN

This chapter discusses:

- The research indicating that all versions of person-centred therapies have been effective with a wide range of clients, problems and age groups
- The strong trend, in the last decade or so, to integrate aspects of other therapeutic approaches with person-centred psychotherapies
- The purpose of integration: to expand and refine the theory and practice of person-centred therapies and increase its effectiveness in clients for whom the traditional model may not be optimally effective

In the last 10–15 years, person-centred therapists (see, for example, Bohart & Tallman, 1999) have increasingly incorporated aspects of other therapeutic approaches into the core model. This reflects a trend in the larger field of psychotherapy in which integration has become a major movement. The integration movement has been spawned by evidence that no single approach to psychotherapy has demonstrated superiority over any other established therapeutic system, and because all approaches have limited effectiveness with some clients. The fundamental premise of this article is that person-centred therapies can be optimized in effectiveness by integrating concepts and methods from other models that more effectively fit the needs of clients who may not respond ideally to the classical approach articulated by Rogers (1959).

The case for integration in person-centred psychotherapies

Carl Rogers was fully aware of the limitations of all theories, his own included. In 1959 when he articulated his 'theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework', he issued the following cautions that have largely been ignored to this day by most students of client/person-centred therapy. Rogers warned:

> I believe that there is only one statement which can accurately apply to all theories … from the theory I will present to the one which *I hope will replace it in a decade* – and that is that *at the time of its formulation every theory contains an unknown* (and perhaps at that point an unknowable) *amount of error and mistaken inference*. The degree of error may be very great … or small, … *but unless we regard the discovery of truth as a closed and finished book, then there will be new discoveries which will contradict the best theories which we can now construct … at the time a theory is constructed, some precautions should be taken to prevent it from becoming dogma*. (1959, pp. 190–1, emphasis added)

In my view, Rogers' theory, now over 50 years old, remains incompletely developed although fundamentally sound as far as it goes. For some practitioners, it lacks sufficient complexity and sophistication to explain how persons develop over the lifespan, how they become psychologically impaired, how change occurs, and how the process of change might be optimally effected. Given the daunting complexity and severity of various forms of psychopathology (for example, schizophrenia), some person-centred therapists may feel a need to incorporate concepts, processes and methods from other models that enhance their ability to assist these clients. Rogers himself was well known for believing 'the facts are friendly', regardless of whether or not they confirmed his hypotheses or demonstrated that it was flawed. A short time before he died, Rogers stated: 'I hope … we're always on the move, to a new theory … to new areas of dealing with situations, new ways of being with persons. I hope that we're always a part of the "growing edge"' (Cornelius-White & Cornelius-White, 2005, p. 396).

Person-centred therapy, although effective for most clients as traditionally practised, has its limitations, as do all therapeutic systems. Experts or critics outside person-centred therapy, and many within the person-centred community, except for the most traditional practitioners, question the belief that the six conditions Rogers (1957) articulated are both 'necessary *and* sufficient' for all clients. Thus, the main reason to integrate concepts and methods from other theories is to better serve those clients for whom the traditional model may prove inadequate. This is not to say that the core assumptions about persons and relationships, which form the base of person-centred theory and upon which person-centred models of integrative practice can be built, are not sound. In this chapter, I explore the possibilities for person-centred integrative practice by examining ways in which various practitioners have moved in that direction.

In the person-centred community, a number of practitioners have advocated the incorporation of a variety of concepts and methods (see, for example, Bohart & Tallman, 1999; Cain, 2010; Cooper & Mcleod, 2011a; Keys, 2003; Worsley, 2004). One of the first to advocate for the 'supplementation' of person-centred therapy was Reinhard Tausch, one of the most productive and respected researchers and practitioners in person-centred therapy and education. Rogers was aware and supportive of the fact that Tausch and his colleagues were incorporating methods drawn from other approaches (for example, systematic desensitization) into the person-centred model of therapy. In the late 1980s, Tausch's research on the effectiveness of person-centred therapy led him to conclude that:

> We as client-centred psychotherapists help some of our clients only insufficiently … it became clear to me [through research studies] that client-centred psychotherapy was a valuable experience in which many people changed significantly. However, some of the clients experienced little or no lasting changes toward greater emotional health. (1990, p. 447)

Tausch was aware that 'clients are occasionally looking for a stimulating facilitation of their self-explorative, cognitive restructuring, information about possibilities of alternative behaviors activities [and that] … many experience this as a very helpful support' (1990, p. 448). He recognized that if therapists were receptive, they would draw from the body of existing information in the fields of psychology, psychiatry and various schools of psychotherapy on behalf of their clients' *wellbeing*. In other words, the needs of a given client would take precedence over the therapist's allegiance to a theory and its typical manner of implementation. This is as it should be if we view helping clients to grow and deal with their concerns as our primary commitment.

Tausch offered some useful criteria for choosing specific supplements to person-centred therapy. He posed the questions: 'What is helpful for *this* client?' and 'What does *he or she* need to facilitate his or her emotional health?' Thus, Tausch is pragmatically client-centred in searching for whatever might be effective. This was Rogers's initial approach when he was beginning to develop his ideas in Rochester (1926–39). Compatible with person-centred values, Tausch suggested that the therapist should not be directive in offering alternatives but, rather, respectful of the client's phenomenal world and desires, thus supporting the client's locus of control. Tausch was clear that any possibilities offered to the client for consideration be validated by empirical research. He also believed that any supplements offered should not be a barrier to client-centred communication. Another criterion was that such supplementations should facilitate the client's independence from the therapist and have a positive effect on the client's self-efficacy during and after therapy.

One of the more important implications of Tausch's proposal is that it broadens the practice of 'client-centred' to include the offering of 'additional therapeutic possibilities which are suited to the individual client's needs [including] … all the scientifically validated options which can help the individual client change his cogni-

tions, emotional-physical reactions and behavior' (1990, pp. 453–4). Tausch's position is important because it: (1) proposes that the core conditions are *not sufficient* for some clients, and (2) provides clients viable options that are effective.

Rogers himself recognized that there was no *one* way to practise person-centred therapy. He took the position that:

> The approach is paradoxical. It emphasizes shared values, yet encourages uniqueness. It is rooted in a profound regard for the wisdom and constructive capacity inherent in the human organism – a regard that is shared by those who hold to this approach. At the same time, it encourages those who incorporate these values to develop their own special and unique ways of being, their own ways of implementing this shared philosophy. (1986, pp. 3–4)

Integrative person-centred approaches

A number of person-centred approaches have integrated aspects of other therapies, including:

- focusing-oriented therapy;
- person-centred experiential or emotion-focused therapy;
- Natalie Rogers' expressive therapy;
- Bohart and Tallman's client-as-active-self-healer model;
- Cain's collaborative-adaptive-pragmatic model;
- Cooper and McLeod's pluralistic model.

Each of these will be reviewed briefly as evolving models of integration.

Focusing-oriented therapy

Focusing-oriented psychotherapy was developed by Eugene Gendlin, whose original contribution is the concept of *experiencing*, which refers to 'the process of concrete, bodily feelings, which constitute the basic matter of psychological and personality phenomena' (1970, p. 138) and to the awareness of an inwardly sensed, bodily felt event of an ongoing process. Gendlin views psychological disturbance as an impairment or block in the person's capacity for processing experience since, without this vital source, there is a constriction in living.

Gendlin fully acknowledges that his approach is grounded primarily in Rogers' core therapist conditions of empathy, unconditional positive regard and genuineness. Gendlin believes that these conditions 'need to be manifested so that they can have an impact, a concrete effect' (1996, p. 297). He believes that reflective listening should be a constant response from the therapist so the therapist can understand the client's meanings. Gendlin briefly summarizes his position as follows:

> *In therapy the relationship (the person in there) is of first importance, listening is second, and focusing instructions come only third*. If something is wrong in the rela-

> tionship, it must be dealt with as soon as possible, and all else must wait. And without listening one is not really in continuing touch with a person. (1996, p. 297, original emphasis)

During the process of focusing-oriented therapy, the therapist helps the client to become aware of and focus on the emerging bodily felt sense of the client's problem. Experiential focusing enables the client to draw on the wisdom of bodily knowing that it creates a fresh and clear understanding of a troublesome experience and points towards a more effective manner of living. Often there are a series of shifts and steps forward as the client moves from one understanding to a fresh variation. These steps tend to lead to a sense of clarity and personal insight that becomes more refined as the client continues to reflect on its meaning and implications for living. Focusing-oriented therapy, and especially the process of experiential focusing, has been incorporated into the practice of various forms of person-centred, existential-humanistic and many other approaches to psychotherapy, often in a seamless manner.

Gendlin's therapeutic approach integrates concepts and methods of other models. In Part 2 of *Focusing-oriented Psychotherapy* (1996), Gendlin devotes over 100 pages to the integration of other therapeutic methods into his model. He integrates aspects of role-play from psychodrama, gestalt therapy two-chair work, experiential dream interpretation, various imagery techniques, aspects of operant behavior therapy, cognitive methods including reframing, a process view of the superego and aspects of the transference concept.

Hendricks' review of the research (2002) demonstrated that:

- higher levels of experiencing in clients correlate with successful outcomes in a variety of therapeutic orientations and client problem types;
- the ability to focus and increase experiencing level can be taught to clients;
- therapists who themselves focus seem to be more effective in enabling their clients to focus.

For a somewhat different perspective on how focusing-oriented therapy fits into the person-centred approach, see Chapter 4. The concept of experiencing itself is considered in more detail in Chapter 7.

Process-experiential/emotion-focused therapy

Working originally with Laura Rice, Leslie Greenberg, along with colleagues Robert Elliott, Jeanne Watson and Rhonda Goldman, has blended the essence of client-centred therapy with elements of gestalt therapy, existentialism and Rice and Gendlin's experiential methods, into an empirically supported therapy they have called emotion-focused therapy (EFT), sometimes initially referred to as *process-experiential therapy*. Pos and Greenberg (2007) describe EFT as:

> An empirically supported humanistic treatment that views emotions as centrally important in the experience of self, in both adaptive and maladaptive function-

> ing, and in therapeutic change. EFT involves a style that combines both following and guiding the client's experiential process, and emphasizes the importance of both relationship and intervention skills. It takes emotion as the fundamental datum of human experience while recognizing the importance of meaning making, and ultimately views emotion and cognition as inextricably intertwined. (p. 1)

In EFT, emotions are viewed as having an inherently adaptive potential that, if activated, attended to and processed, enables clients to alter problematic emotional states and troublesome self-experiences. The emotion theory on which EFT is based suggests that client emotion influences modes of processing, guides attention and enhances memory. A considerable amount of client behavior is seen as oriented towards emotion regulation and attachment. Emotions are understood as expressions of clients' most essential needs, signals that alert them to the state of their *wellbeing* and act as guides to take action in meeting essential needs. One of the intents and effects of EFT is to enhance the client's emotional intelligence. From an emotion-focused perspective, disorder is seen as resulting from failures in the regulation of affect, avoidance of affect, traumatic learning and lack of processing of emotion (Elliott, Greenberg, & Lietaer, 2004).

Grounded in a client-centred relationship, Greenberg is clear in emphasizing that the client and the quality of the relationship always take precedence over the therapeutic tasks proposed, methods or goals. All tasks are mediated through the empathic bond that is formed out of careful following and empathic attunement. The EFT therapist also realizes that task collaboration is paramount and that productive therapy cannot occur unless the client and therapist are working together to solve the client's problems.

The literature on client processing of emotion reviewed by Greenberg, Korman and Paivio (2002) concluded that:

- processing information in an experiential manner is associated with productive client involvement and predicts successful outcome;
- therapies focusing on clients' emotional experience, when successful, are associated with changes in clients' in-session emotional experiences;
- emotion is important in reorganizing personal meaning;
- research on therapist processing of client emotion indicates that the individual's ability to accurately differentiate his or her emotional experience is integral to healthy functioning.

In an extensive review of the literature Elliott et al. (2004) concluded that 'experiential treatments have been found to be effective with depression, anxiety, and trauma, as well as to have possible physical health benefits and applicability to clients with severe problems, including schizophrenia' (p. 510).

For a different look at how the process-experiential/emotion-focused approach fits in with person-centred therapy, see Chapter 4.

Natalie Rogers' person-centred expressive therapy

Carl Rogers' daughter, Natalie Rogers, has developed an approach to psychotherapy that integrates the use of creative expressive modes with person-centred principles. She embraces her father's basic philosophy that 'Each individual has worth, dignity and the capacity for self-direction if given an empathic, non-judgemental, supportive environment' (www.nrogers.com, 2008). She also credits other prominent humanistic psychologists who have influenced the development of person-centred expressive therapy including Abraham Maslow, Rollo May, Clark Moustakas, Art Combs and Sidney Jourard. What these pioneers share, according to Natalie Rogers, is a relational model of personal growth in which the therapist respects the client's dignity, value and capacity for self-direction.

A foundational premise of Natalie Rogers' therapeutic approach is that the therapeutic process 'helps awaken creative life-force energy … [and] What is creative is frequently therapeutic' (N. Rogers, 2007, p. 316). Among the modalities employed are dance, music and art therapies, journaling, poetry, imagery, meditation, improvisational drama and any other means of creative expression that clients might wish to use. Natalie Rogers has observed that the use of one expressive art form often fosters the use of others and results in a 'creative connection' enhancing the process of self-discovery while deepening affective experiences and discovering personal meaning. Art is understood as a form of language that provides an 'alternative path for intuitive, imaginative abilities supplementing traditional, logical, linear thought [that] … move the client into emotions yet add a further dimension, release of the "free-spirit"' (2007, p. 318). According to Natalie Rogers, clients indicate that the use of creative arts enables them to discover and deepen their sense of self, identify inner truths and values, transcend problems, gain a fresh sense of their soul or spirit and achieve constructive change.

Natalie Rogers indicates that person-centred expressive therapies have been found helpful with a number of populations or problems including self-help groups, 12-step substance abuse programmes, individuals who have been sexually abused, grieving persons, anger problems and children in play therapy. A research study conducted on 32 participants of Natalie Rogers' workshops found increases in self-awareness, improved self-confidence and deeper self-exploration. (For more on Natalie Rogers' approach, see Chapter 16.)

Bohart and Tallman's model

Bohart and Tallman, authors of *How Clients Make Therapy Work* (1999), have made a compelling case that it is the client, rather than the therapist, who is the primary agent of constructive change, a notion derived from Rogers' view of clients as resourceful and as having an inherent tendency to actualize their potential. They cite considerable evidence that client involvement in therapy is the most important factor making therapy effective. Consequently, therapists strive to support, stimulate and

encourage client investment in therapy. Bohart and Tallman (1999) view therapy as a learning process and contend that engaging the client's self-healing potential is essential in helping them.

Bohart believes that when therapists truly respect their clients and see them as the agents of change, therapists should trust them to be able to make decisions about their own therapy, which might include what the therapist and client do together. He emphasizes a 'meeting of minds' between therapist and client that facilitates two intelligences working collaboratively together. Bohart trusts clients to know what is best for them and, consequently, is not hesitant to offer or suggest procedures that they might find useful. He comments, 'because it is collaborative and I respect them and their path I never assume the expert stance of knowing what is best for them. I assume they will be able to decide and respect what is good for them' (personal communication, 2011). Bohart is also open to clients suggesting things, to their modifying things, to their creatively adapting things, because they are the expert on themselves. He views himself as 'a client-directed integrative therapist, integrative in the sense that I come from a person-centred base but am willing to use whatever that may be useful to the two of us together, with the client as the expert on what to try and what to use' (personal communication, 2011).

Cain's collaborative-adaptive-pragmatic model

I have developed a model (Cain, 2010) that draws heavily from and integrates research and theory from other humanistic-existential therapies and, selectively, a body of knowledge from the larger field of psychotherapy, psychology and any promising sources (for example, health and philosophy). This model is grounded in pragmatism, collaboration and therapist adaptability, and is intended to broaden the scope of what it means to be person-centred and expand the range of effective practice.

One of the major shifts evident in the field of psychotherapy is that therapists are moving towards increasingly involving their clients in all aspects of the therapy (see, for example, Bohart & Tallman, 1999; Cain, 2010; Cooper & McLeod, 2011a). Advocating for a collaborative therapeutic approach, Vollmer, Grote, Lange and Walker (2009, p. 34) cite the American Psychological Association's Presidential Task Force on Evidence-Based Practice that 'psychotherapy is a collaborative enterprise in which patients and clinicians negotiate ways of working together that are mutually agreeable and likely to lead to positive outcomes'. Their preliminary findings indicate that clients liked being offered choices and found it important to be included in the decision-making process about their therapy.

In this collaborative-pragmatic-adaptive approach, the therapist and client individualize each therapy by being partners in the definition and understanding of the client's problems, desired goals and means to achieve those goals, and the identification and development of an optimal therapeutic relationship. This approach takes the position that person-centred therapists cannot maintain that clients know what is best for them and, at the same time, define a priori what specific conditions are necessary and suffi-

cient for all clients. Since each client and each course of therapy is unique, clients need and benefit from different things at different times. Therefore, each course of therapy needs to be co-created by therapist and client working cooperatively together.

A second major characteristic of this model is the therapist's adaptability to recognize and employ 'what fits' and 'what works' at various points in therapy. Clinical wisdom and many prominent therapists (see, for example, Lazarus, 1989) point to the importance of individualizing therapy. It is the therapist's responsibility to adapt and accommodate in a manner that works best for a given client. As therapists take the role of mindful observers and learners in relationship to their clients, they are likely to enquire about what is needed or likely to be most fruitful in specific situations.

A third guiding principle of this approach is pragmatism. Consequently, the therapist's commitment is to *do whatever is in the best interests of the client*, regardless of whether it fits with the person-centred theory from which one currently operates. The therapist draws on whatever provides the best evidence, or holds the most promise, for assisting our clients at a given time in their therapy. Consequently, fostering clients' active involvement in all aspects of their therapy is critical in effecting constructive change.

Consistent with a collaborative-pragmatic-adaptive approach, the therapist brings forth *for the client's consideration* any and all personal and professional resources that may be of value to the client. In some cases, our clients do not know what they need to help them think, feel and do better, but they certainly recognize what is helpful and what is not. Thus, therapists depend on their clients to assess the value of whatever their therapists might offer.

This model of person-centred therapy alters the premise that therapists remain absolutely non-directive in their approach to clients since doing so may restrict the availability of the therapist's professional and personal resources. In this approach, therapists are free to offer non-coercively whatever is believed to be in their clients' best interests, while clients are ultimately free to choose what fits and reject what does not.

Cooper and McLeod's pluralistic approach

In recent years, Mick Cooper and John McLeod, both closely associated with the person-centred field, have developed an approach to counselling and psychotherapy that they have termed 'pluralistic' (Cooper & McLeod, 2007, 2011a, 2011b). They argue that this approach emerges from a person-centred ethic (Cooper & McLeod, 2011b) and see it as a framework for re-conceptualizing what it means to be person-centred, as well as a framework and practice for the wider therapeutic field.

Cooper and McLeod's (2007, 2011a, 2011b) pluralistic reading of what it means to be person-centred shares many of the values and principles emphasized by Bohart and Cain. They argue that a truly *client*-centred approach starts with an understanding of the client as an active agent of change within the therapeutic relationship; and that an ethic of valuing the client's perspective, wants and experiences means being open to the many different things that clients may want within therapy. Hence, they

suggest that a 'dogmatic' person-centred stance (Worsley, 2001, p. 25), one that engages with the client in a non-directive way irrespective of what the client may actually want or ask for, is antithetical to the core values of a person-centred approach.

However, Cooper and McLeod (2011a) emphasize that adopting a pluralistic perspective on counselling and psychotherapy can be considered to be distinct from adopting a pluralistic/integrative way of working. Hence, a person-centred therapist might adopt a pluralistic outlook, appreciating the different things clients may need and valuing alternative forms of therapeutic practices – both within and outside the family of person-centred therapies – while at the same time choosing, themselves, to specialize in non-directive ways of working. The differences between this and a more dogmatic person-centred stance is, for Cooper and McLeod, the willingness of the practitioner to acknowledge that their approach is just one method that may be helpful to the client, to be open to discussing this with them and to willingly refer out where appropriate.

Like Cain, Cooper and McLeod put considerable emphasis on 'meta-communication' (Cooper & McLeod, 2007, 2011a, 2011b) with clients: discussing with them the particular things that they want from therapy, and the methods that they think may be most suited to helping them arrive at that point. The emphasis here is on listening closely to clients and being flexible, and also on therapists being willing to introduce their own ideas and expertise into the dialogue. The exchange in Box 17.1, for instance, comes from Mick Cooper's work with a client, Saskia (Cooper & McLeod, 2011a).

Box 17.1

Meta-communicating on therapeutic methods

Mick had asked Saskia what she thought might be helpful to her in the therapy and what she had found helpful or unhelpful with previous therapists. Saskia replied that she had found it unhelpful when there is 'just a man sitting behind you' not giving you any feedback. She said that she wanted lots of input and guidance. Mick was fairly happy to work in this way. However, he had also sensed that Saskia had a relatively 'externalized locus of evaluation' (that is, she tended to look towards others to tell her what to do) and he had some concerns about simply reinforcing this.

Mick: So it sounds like feedback will be useful?

Saskia: Yeah, Yeah.

Mick: OK.

Saskia: Yes, definitely, because … no matter who we are in the world, wherever we are in life, there is always going to be something that we've missed, either because we don't want to see it, or because we just didn't see it. Even if someone is 90 per cent 'actualized' …

they're not going to see everything. [So] you [can] turn around and say: 'You could have said this, you could have done that.' And they're: 'Oh, really, thanks Mick, I never – I never saw that.'

Mick: I guess the important thing for me, in giving feedback, is that you can say 'That's not right' [*Saskia*: Sure.] And you can say, 'No, that doesn't fit,' or 'That's not helpful' [*Saskia*: Sure, sure.] I mean, one of the ways that I like to work is – is very much with feedback … and that needs you to say to me, 'No, I don't like that …' or 'That's good …'

Conclusion

Each of these integrative approaches is clearly grounded in Rogers' core beliefs about therapy, with varying degrees of emphasis, while integrating concepts and methods from other therapeutic systems. One thing that all of these integrative versions share is greater input from the therapist, often in the form of process guidance. Therapists are more often active participants in all aspects of therapy and bring ideas about what might help to enable clients to make better use of various therapeutic processes (for example, focusing, two-chair work or the use of creative expression). All value the maintenance of the client's autonomy and self-direction, and consider the client to be a collaborative partner in the therapeutic endeavour. None of the approaches embraces a strict non-directiveness, instead taking the position of being relatively more or less directive depending on what best serves the client.

In conclusion, it appears that integration represents the present and future of optimally effective psychotherapies. The integrative movement challenges therapists to reflect critically on the strengths of one's current approach and suggests that theoretical allegiance should never limit therapists in doing what is in the best interests of their client, regardless of whether it fits with or diverges from their theory of psychotherapy.

Points for reflection

- As you consider integration, what concepts and response styles or methods might you incorporate from the integrative models described in this article or from other therapeutic systems?
- If you embrace a traditional or classical view of person-centred therapy, what concerns might you have about altering your therapeutic approach and the effects it may have on your clients?
- How do you imagine that your clients may be better served by integrating other approaches with your current model?

Key readings

Key texts for the integrative models discussed in this chapter are:

- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.
- Cain, D. J. (2010). *Person-centered psychotherapies*. Washington, DC: American Psychological Association.
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Part III

Client groups

Edited by Mick Cooper

Part III addresses the application of person-centred counselling and psychotherapy to a range of client groups. In the early years of the development of the person-centred approach (PCA), researchers and practitioners made few distinctions among different client populations (see Chapters 1 and 29). This absence was common in much of the psychological literature. We know from description of workshops, counselling tapes and the rich oral history of the PCA that clinical studies did include persons of colour, of varying sexual and gender identities, and with diverse forms of problems; but, for Rogers, these aspects of his clients' reality were not his focus. He was interested in getting at what he thought were the universals underlying psychological processes, and it was for succeeding generations to extend the core hypotheses of the person-centred approach to wider and more particular client groups.

As the approach expanded into more areas of practice and more varied demographic and problem-related groups, so specialized approaches developed to meet the particular needs of these diverse populations. As Colin Lago and Tatsuya Hirai's chapter (Chapter 29) shows, the past decades of research have revealed the limitations of a universalist stance and the significance of particular contextual realities such as race, age, sexuality and gender, class, physical ability, religion and national origin.

A comprehensive catalogue of the multiple and varied ways of applying person-centred therapy to diverse client populations is beyond the scope of this Handbook. However, in the following chapters, we discuss the application of person-centred ideas and practices to eight key client groups: children and young people, couples and families, older people, people experiencing bereavement and grief, people with contact-impaired functioning, people experiencing difficult processes, people traumatized and in crisis, and people struggling with addictions.

Our choice of client groups to focus on has been guided by a number of factors. First, we wanted to focus on groups who were relatively prevalent – who would be encountered in the consulting room on a fairly regular basis. Second, we wanted to look at groups for whom there was some body of literature on how person-centred ideas and practices might be applied. Third, we were interested in looking at client groups for whom person-centred writers had made particular contributions to understanding the issues and processes involved: specifically, clients with contact-impaired functioning (Chapter 22) and difficult processes (Chapter 23).

The aim of these chapters is twofold. First, it is to show the value and application of person-centred theory and practice to these client groups,

with each of the chapters pointing to the relevant empirical research. Second, the chapters aim to guide person-centred therapists on how their understandings and practices might be enhanced when working with clients from these different groups. The assumption here is that readers are relatively familiar – or developing a familiarity – with the core person-centred practices outlined in Part II of this book and are now ready to look at how these modes of relating might be extended to particular client populations. Throughout the chapters, client studies and actual dialogues are presented in order to illustrate, as fully as possible, the actuality of work with these clients.

Clearly, from a person-centred standpoint, the aim of these chapters is not to suggest that *all* clients from a particular group can be engaged with in a similar way. Each of the groups discussed in this part of the book shares certain characteristics, but beyond that there will be enormous diversity in how each person within them will experience their world – and therefore a great deal of diversity in what they may find helpful or important in therapy. These chapters should therefore not be taken as guidelines for practice with particular 'types' of clients. Rather, they should be taken as resources for understandings and practices that may, we hope, be of value – in practice, in reflection, in supervision – when working with clients from these particular populations.

The first chapter in this part of the book, Chapter 18, a new contribution to the Handbook, looks at person-centred work with children and young people. It is co-authored by Michael Behr and Dagmar Nuding, from the University of Education, Schwäbisch Gmünd, Germany, and Susan McGinnis, who has led the development of school-based counselling for young people in Glasgow, UK. In the UK, work with children and young people is a particularly important area of emerging person-centred practice, with school-based counselling – of a predominantly person-centred or humanistic orientation – an increasingly established provision within the educational sector. The first part of the chapter looks at person-centred play therapy, primarily with younger children, introducing the different forms that this work can take. The chapter then goes on to look at person-centred counselling work with adolescents, exploring the challenges and relational and professional issues involved with this work.

Extending this developmental focus, Chapter 19 examines the application of person-centred therapy to work with families and couples. It is written by family therapist Charles J. O'Leary, author of *The Practice of Person-centred Couple and Family Therapy* (Palgrave, 2011) and his colleague Martha B. Johns, both from the USA. The chapter introduces the literature and context of this work, and offers very practical guidance on developing as a person-centred therapist in this area.

Chapter 20, another new contribution to the Handbook, completes this developmental journey by looking at person-centred work with older people. The chapter is a collaboration between Allyson Washburn, Associate Professor at the National University, California, USA, and Sofia von Humboldt of the Portuguese Association for Person-Centred Psychotherapy and Counselling. With an ever-increasing older population across the globe, work with this client group may be of growing importance for the future. The chapter presents an understanding of ageing and the developmental stages of later life that can be incorporated into person-centred theory and practice, and considers the specific application of the core conditions of the person-centred approach to this population.

Chapter 21, on person-centred counselling with clients experiencing grief and bereavement, is a third new contribution to this part of the Handbook, written by Dale G. Larson, Professor of Counselling Psychology at Santa Clara University, California, USA, who has become an important and passionate advocate for this approach. This is an area in which person-centred practice is often considered particularly appropriate. As with the previous chapter, it begins by reviewing some key theories in this area that are consistent with, and relevant to, person-centred practice, before going on to describe and illustrate how person-centred work with the bereaved can be practised.

The following chapter (Chapter 22) looks at person-centred work with people who are contact-impaired – those who struggle to be in psychological contact with the world around them and the affective world within them – in particular, people experiencing psychotic functioning and/or with special needs. This chapter introduces the theory and practice of Pre-Therapy, one of the most important recent developments in the person-centred field (see Chapter 4). The chapter is co-authored by Garry Prouty, the founder of Pre-Therapy, who very sadly passed away in 2009, and Dion Van Werde, who is coordinator of the Pre-Therapy International Network and a leading advocate of the approach. The chapter gives a concise and comprehensive introduction to Pre-Therapeutic theory and practice with contact-impaired clients, vividly illustrating how the work can unfold and help clients to re-establish psychological contact.

Following on from Pre-Therapy, Chapter 23, on working with difficult processes, represents another major person-centred contribution to an understanding of severe psychological disturbance. The chapter is

authored by Margaret S. Warner, Professor of Psychology at Argosy University, Chicago, USA, whose work on difficult and fragile processes has been highly influential in the person-centred field in recent years. Warner's chapter presents the psychological and developmental theory behind these understandings and discusses their implications for practice.

In the aftermath of such disasters and the Japanese tsunami in 2011, as well as the countless private crises that occur every day, there is growing awareness of the urgency of developing approaches that are effective with people in crisis and who have experienced trauma. This is explored in Chapter 24 by Lorna Carrick and Stephen Joseph, UK-based psychologists and academics who have specialized in these areas for many years. Carrick and Joseph show how, from a person-centred perspective, even the greatest challenges in a person's life can be seen as an opportunity for growth and development; and they discuss the practical implications for therapists working in this area.

The final chapter in this part of the book, another new contribution, is on working with clients with addiction issues and has been written by J. Roland Fleck at the National University in California, USA, and his wife Dorothy Fleck, who very sadly died in 2012. The chapter discusses the theoretical and empirical background to working with addictions, and introduces the practice of motivational interviewing, which has been described as 'client-centred therapy with a twist'. The twist is that motivational interviewing has several more directive and goal-orientated elements than are seen in more classical forms of person-centred therapy, and this means that it is not always seen as sitting easily within the person-centred fold. However, as a person-centred-based therapy of growing international importance, and with a strong evidence base behind it, it makes a very valuable contribution to this edition of the Handbook. Along with discussing the relationship between motivational interviewing and more established person-centred practices, the chapter presents a clear and practical guide to the basics of motivational interviewing practice.

While each of the chapters in this part of the book focuses on different understandings and practices across client groups, they all point towards a unifying core: that a person-centred approach begins with the strengths and potentialities of its clients, whatever their challenges – whether facing death, crisis or severe mental disabilities – rather than their 'pathologies', 'disorders' or limitations. Regardless of their particular characteristics, the core faith is in people's abilities to reach their full potential, together with appropriate encouragement and support that can facilitate a shift towards wholeness and higher levels of functioning.

18

Person-centred psychotherapy and counselling with children and young people

MICHAEL BEHR, DAGMAR NUDING AND SUSAN MCGINNIS

This chapter discusses:

- Play, as a child's natural activity, as a core element in therapy with children to enable self-exploration and communication
- Different orientations in person-centred work with children and young people, including classical non-directive therapy and interactive, experiential and integrative approaches
- The importance of congruence for interactive therapy and for work with adolescents
- The presence of caregivers in therapeutic relationships and issues of capacity, consent and confidentiality with young clients
- Process and outcome research from person-centred therapy with children and young people

Although Carl Rogers spent the first 12 years of his professional life as a therapist for children and young people, he had little to say about them once he began to develop and present the ideas that became the person-centred approach. He does, however, make reference to adolescents with regard to the therapeutic relationship and what he calls 'acceptance' as the agent of change, especially with clients where access to

their frame of reference is difficult; here, he used the case of Joan, a young girl who attended counselling regularly but did not speak, and some case studies with adolescent boys, as illustrations (Rogers, 1951).

In his early work, the word 'permissiveness' appears to describe the concept of unconditional positive regard, a term that today is frowned upon when used in reference to children yet captures something of what he perceived as a most significant element of therapeutic relationships with young clients. Rogers also collaborated on a research study aimed at identifying the determining factor in predicting future behaviour in young people with conduct problems, which showed what he called 'self-insight' as the highest rated factor, in contrast to his expectation that the key predictor would be found in the young person's environment (Kirschenbaum & Henderson, 1989, pp. 206–11). And while his first book, *Clinical Treatment of the Problem Child*, predates the person-centred approach, his belief that children and adolescents should not be defined by their behaviour is made clear on the first page (Rogers, 1939).

Children, young people and parents in person-centred play therapy

Therapy with children, young people and their caregivers can differ considerably from therapy processes with self-reflective adults, who can talk about distress and are able to take a meta position on how they feel, think and act. A child tends to establish an inner relationship to the world and to him- or herself mostly by using toys and engaging in play. Therapists often label this play as symbolic: the child acts out inner topics and feelings, and the play has something to do with what is happening around the child. Scenes and play processes are symbolizations of this, parallel to adults using language and finding new wordings for experiences (Behr, Hölldampf, & Hüsson, 2009; Cochran, Nordling, & Cochran, 2010c; Goetze, 2002; Landreth, 2002; Schmidtchen, 1989; Smyth, 2012; Weinberger, 2005). Children under the age of 3 years can, in principle, also receive play therapy from an adult who empathically tunes in to the child's actions. However, the established therapeutic intervention for babies and toddlers is to foster the child's attachment to the parents and to train the parents to respond with empathic and attuned actions.

Once children are 11 or 12 years old, the way to connect to them gradually shifts. They become more talkative, sometimes playing games during the session to regulate the distance to the therapist and to their problem. They can shift to take a meta position towards themselves and towards their problems but may need a more active therapist than adults do in order to follow through an experiential process (Geldard & Geldard, 2006; Weinberger & Papastefanou, 2008). In person-centred work with children and young people, there are different positions (as illustrated in Box 18.2 below), ranging from classical person-centred work to a more experiential integrative way of working.

Person-centred play therapy

Special features of play therapy with children, adolescents and parents

Therapy with children includes two main challenges that demand special training and research approaches.

Play is the dominant medium of self-exploration and communication

Person-centred play therapy meets children by using play as a core element. Play is a natural activity of children; it is their basic way to communicate with the therapist and stage their inner reality. Conflicts and traumatic live events are presented, repeated and changed until the child is able to integrate the situations into his or her self (Box 18.1). As the therapist neither interprets nor directs, the imagery of play allows the child to explore in a safe way. The therapist tunes in to this symbolic speech and detects and responds to those kinds of symbols. Research shows that children aged 10–13 years on average used play for 43–45 minutes of a session, whereas they only talked during 9.5 minutes (Schmidtchen, Wörmann, & Hobrücker, 1977).

Person-centred play therapy acknowledges that children have the capacity to set their goals and act out their problems through play (Axline, 1947; Landreth, 2002). Communication in play therapy is a special challenge because play is precise in a way that is different from verbal communication, and the therapist has to parallel these two modes. In addition, children seek specific relationship modes: the therapist is an adult, an alternate parent, a play partner or the child's lawyer.

Box 18.1

Play as a medium to symbolize the child's inner world

Kate has experienced her parents' divorce and father's new marriage, preceded by a 2-year period in which her father loved her mother and his later new spouse at the same time. In her play with dolls, each male figure always has two women.

Two adopted siblings rivalled for their new parents' attention and acted out their topic via play. The therapist had to be a prince, and he had to choose one spouse out of the two princesses who were attracting him in a competitive way.

Caregivers and often the young person's social environment must be attached to play therapy

'It's not the boy, it's his stupid mother who needs therapy', the divorced father claims. 'Counsel the parents, not the child!' 'Only work with the whole family!' Spontaneous theories like this neglect the dramatic distress and manifest disturbances and

incongruence now implemented in the child's mind. The young person needs specific help. In more than half of the cases seen by a child and adolescent therapist, any family system that might have caused the child's trouble is no longer existent. Patchwork families, grandparents, foster parents or home facilities care for the young person. However, for young children the present caregivers, the teacher and other significant people in the young person's life have to be involved, and their legal status has to be taken into account.

Usually, caretakers initiate the contact with the therapist and participate in the first meeting. For practitioners working in medical settings, information from caretakers is important for diagnosis and planning treatment (Behr, 2006). Even though parents and young clients sometimes have a troubled relationship with one another, the therapist has to win the trust of both. This can complicate the beginning of therapy. The therapist has to balance the interests of parents and children. In addition, it is not appropriate for the child to learn about any parent's problem, and parents should not know the details of what is happening within the play sessions.

During play therapy, regular full session-length meetings with the caretakers are scheduled. Caretakers differ widely in their emotional and social competences. Very self-explorative parents who use the meetings like their own therapy to clarify their feelings and interactive modes towards the child contrast with parents in need of directive advice to survive everyday life.

There is a lack of concepts and research on how to counsel parents during play therapy. With young people, the weight of caretaker counselling is reduced, but agreement and cooperation are also crucial, depending on legal and cultural issues. Contributions are provided by Kraft and Landreth (1998), Killough-McGuire and McGuire (2001) and Fröhlich-Gildhoff (2003). Person-centred family therapy (O'Leary 1999) and trainings such as parent-relationship enhancement training (B. Guerney, 1984) or filial therapy (Goetze, 2001; L. Guerney, 1997) are described in other chapters (Box 18.2).

Box 18.2

Milestones in the development of person-centred play therapy with children, adolescents and parents

- Psychoanalysts Hermine Hug-Hellmuth (1913), Anna Freud (1927) and Melanie Klein (1927) claim to use play as the medium for psychoanalysis.
- Virginia Axline (1947) develops her method of non-directive and non-interpretative unfolding of experiential processes in play.
- B. Guerney (1964) conceptualizes filial therapy: parents are trained in basic child-centred play therapy skills to become the therapeutic agent of their child.
- Schmidtchen (1974, 1976, 1989) develops operationalizations of therapist behaviour and establishes broad process and effective factors research in Germany.

- Landreth (1982, 2001, 2002) establishes broad training and research facilities in the USA. Major concept differentiations occur for play and filial therapy (Landreth & Bratton, 2006), with extensive outcome research.
- Major concepts of work with families are debated (O'Leary, 1999; Gaylin, 2001).
- Concept extensions occur towards interactional (Behr, 2003, 2012) and experiential work (Geldard & Geldard, 2004, 2006; Goetze, 2002; Weinberger, 2005).
- Major outcome research initiatives are set up (Baggerly, Ray, & Bratton, 2010; Bratton, Ray, Rhine, & Jones, 2005; Hölldampf, Behr, & Crawford, 2010).

Two modes of person-centred play therapy

During play therapy, the child acts out on two levels. First, the child creates play scenarios with significant meanings within his or her everyday life. In addition, the young person acts out schemas on feelings and behaviour within the relationship with the therapist. The therapist responds on both of levels: with empathic comments on the play process – and by responding like a real person in joint play or on real issues.

Launching person-centred play therapy

Roger's doctoral assistant, Virginia Axline (1947), transferred his core conditions into the play room even before his major works were published. Her eight basic principles highlight the child's self-agency in a touching way, using wording that seems to be the most cited sentences on play therapy (Axline, 1947, p. 67ff):

1. 'The therapist is genuinely interested in the child and develops a warm, caring relationship.'
2. 'The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.'
3. 'The therapist creates a feeling of safety and permissiveness in the relationship so that the child feels free to explore and express self completely.'
4. 'The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.'
5. 'The therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.'
6. 'The therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship and resists any urge to direct the child's play or conversation.'
7. 'The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.'
8. 'The therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility.'

Even now, Axline's deep conviction in trusting non-manipulated development with non-possessive and unconditional positive regard fascinates child therapists of all paradigms. While grounded in empirical research, an ethical and philosophical dimension transfers her concepts far beyond mechanistic thinking in therapy.

Axline's (1947) principles pioneered the person-centred play therapy work that is practised today. Reading her work and case studies (Axline, 1964), a vision of a therapist emerges who tracks the child's self-directed play in a most empathic manner while sitting on a chair and taking down in shorthand every communication, and who only joins play when explicitly demanded by the child. She acts in a facilitative mode.

The facilitative mode of play therapy

Rogers used the term 'facilitative' to define a non-possessive, non-intrusive helping that opens options by clarifying the client's feeling, thinking and aims. Therefore the play therapist tunes in with the child by an intense presence, giving empathic comments on the child's acting and circulating in the room (Box 18.3). The therapist is like an alter ego while the child is staging and acting out his or her issues (Cochran et al., 2010c; Landreth, 2002; Weinberger, 2005).

Box 18.3

Non-interpreting empathic attunement of the therapist

Vera is playing in the dollhouse. The male doll and the girl doll are in the bathroom. Vera places the head of the male doll into the toilet bowl and screams with joy. The therapist says, 'The head is in the bowl now. That's exciting.'

Stephan is playing with the knight's castle, where the grandfather is sitting in the dungeon. Stephan's knight is searching for the grandfather and wondering where some screams are coming from. While searching, he is doing a lot of other things, like tidying up the castle. The therapist comments, 'It seems like finding the grandfather is not the most important thing.' Stephan smiles. The therapist responds, 'It seems like the little knight does not really want to find him.' Stephan is still smiling, lifting his shoulders, saying, 'Maybe.'

During play therapy, the child is working on what we call *self-exploration* when counselling adults. While the adult shifts to a symbolization by connecting bodily holistic experiences to language ('Oh yes, disgust is the feeling I always have when …'), the child mainly symbolizes via play scenarios. The child's non-directive play is fed by vague, fractured or ambiguous mental representations; this becomes visible in

a play scene and a gestalt may emerge. The fractioned elements build up towards an emotional schema (Behr, 2009). Thus an outlined and meaningful experience is created within the play scenario. This could be, for instance, a picture (a farm with all sorts of animals and facilities), a scene (the boy puppet sadistically smashes the doll house), an action (the child is cooking for herself and the therapist) or a new role (the knight protects a family). The child takes home such experiences. They are representations of the child's experiencing of the self and the social environment. The *symbolizations* are now experienced as *part of the self*. Experiences and self are better matched. The child becomes more congruent.

Research found that, even in a facilitative mode of play therapy, the child is seeking joint play for 30 per cent of the time given (Schmidtchen, 1978). After the child has been stabilized, fed and reassured by facilitative responses for weeks or months, many young people now seek a therapist who can be encountered as a real person. When this happens, the process shifts into an *interactive mode* (Behr, 2012).

The interactive mode of play therapy

Relationships, encounter and contact are parts of human needs. Without relationships, human beings cannot experience their self. Being a person means creating separation and autonomy, but also being in relation with others and defining oneself throughout interactions with others. Rogers grounded his theory on Martin Buber's dialogic philosophy (Buber, 1937). Today, Schmid (1997, 2008), Mearns and Cooper (2005) and Mearns and Schmid (2006) represent this interactional understanding of being a person. Change processes result out of deep relationship experiences with the therapist or in groups (see Chapter 5).

When the therapist welcomes joint play with the child, this will govern the immediate encounter, interactions and negotiations on all sorts of issues. The therapist responds to the child's actions on the level of action. He or she is doing something similar, which is attuned to what the child did. While doing this, the therapist is empathic on the verbal level, is responsive, tunes in with the child's affects and at times mirrors what the child is doing, although *not too literally*. Thus, the therapist is moved by the child's actions and reflects them in a modified way by not adding to them. He 'only' takes up and changes the tone. That is resonance in an interaction (Behr, 2003, 2012).

On the level of both creativity and activity, the therapist will try not to go ahead of the child, as that would be directive. But the therapist will also not remain too far behind the child, as that would reduce the therapist's immediacy and presence and might become boring. In the interaction, the therapist uses the media the child chooses while offering *interactive resonance* by his or her own way of acting. The example in Box 18.4 demonstrates how the therapist accomplishes a shift in therapy by switching from an orthodox clarifying and supportive behaviour to interactive resonance.

Box 18.4

Example of a switch from faciliative to interactive mode

Karen wants to build a tower by piling up the chairs in the play room, putting them on the table and then sitting on top of them. The therapist starts to do the same and competes with her in building the highest tower.

In earlier sessions, the therapist helped Karen during the same game by verbalizing her emotions, motivations and cognitions, as suggested by the facilitative mode of non-directive play therapy. For Karen, this was stabilizing and clarifying. When she performed her game in the previous session and the therapist again commented empathically and assisted, it was rather boring for both of them. Now it is about the relationship, about competition, about who is the boss. Now the therapist, with his interactive resonance, has grasped the inner issue of the child as a relationship issue. At the end of the session, both are sitting on their chair towers and discussing whose is the bigger and has more to say.

Being confronted with the therapist's different behaviour, Karen could experience herself dealing with issues such as competition and power. It is likely that symbolization took place and that it was deep and persistent, as she experienced it in a real relational situation.

Interactive resonance primarily represents an enhancement and a modification of the client-centred core condition of *empathy*. However, it also has a lot to do with the *authenticity* of the therapist. In reaction to what the child does, the therapist acts and focuses on the relationship by showing him- or herself as a person who is present and who gets personally involved in the relationship (Behr, 2009).

Person-centred therapy with young people

The person-centred therapist working with young people faces a number of challenges:

- having faith in the actualizing tendency of an organism that is changing at great speed, often in a leap-frog motion where physical development precedes the emotional capacity to control and reflect;
- valuing equally all thoughts and feelings in our clients' frame of reference, even when those thoughts and feelings may frighten us and make us want to value some higher than others in order to guide or protect;
- working within institutions, such as schools, whose primary purpose is to control and to safeguard, when our ethos asks us to be expansive, open and trusting in our clients' potential and tendency towards growth;

- being expected to 'fix' conduct that is troublesome while holding the belief that behaviour is an expression of the most fundamental process that drives us: an attempt to maintain and enhance the organism.

Recent writing on the person-centred approach with adolescents tends to focus either on the client group (Keys & Walshaw, 2008; Prever, 2010), on the context in which the work takes place (Boy & Pine, 1963) or on working with specific subgroups such as those with behaviour problems (Cochran, Fauth, Cochran, Spurgeon, & Pierce, 2010a, 2010b) or disabilities (Ommanney & Symes, 2000). In addition, two comprehensive textbooks offer integrative concepts for person-centred and experiential work with adolescents: Geldard and Geldard (2004) and Weinberger and Papastefanou (2008).

The therapeutic relationship with young people

Person-centred therapists skilled in working with adults can wonder what they are supposed to do when faced with an adolescent client, as if ways of being and holding certain beliefs and attitudes suddenly feel insufficient. All theory and practice remains, however, the same, although some aspects of counselling young people distinguish it from working with other client groups.

Adolescence is second only to infancy in the speed and complexity of the development of the human organism. Physical, cognitive and social changes occur, sometimes in apparent disharmony with each other, presenting the therapist with a broad range of possibilities for engaging in the client's frame of reference based on developmental stage rather than age. An 11-year-old may wish to sit face to face and talk, while play therapy has been shown to be effective with aggressive 18-year-olds (Cochran et al., 2010a, 2010b). Some person-centred practitioners incorporate creative approaches such as drawing or writing into their work, both as an expressive medium and a means of creating some distance between experience and the expression of difficult material for young clients.

Where the counsellor prefers not to use creative approaches, it is still a good idea to have in the room some drawing materials, perhaps a ball that is soft enough not to do damage when thrown and some small objects that are stretchy or flexible. Young people often like to have something to hold in their hands and to play around with while they talk, especially if they are anxious or have a particularly uncomfortable issue to share.

Adolescent clients are 'present-centred'. They may not sit and reflect on the impact of past experience, or sometimes even on how they are feeling in counselling sessions. In a study that asked a group of third-year secondary school pupils (age 13) how they felt on the day of the survey, many responded not with words about feelings but by saying what they did that day, such as meeting with friends or playing football (Gordon & Grant, 1997). Similarly, as clients, young people are likely to use the counselling session to talk about what is happening in the here-and-now, describ-

ing events in terms of who, what, where and when. A counsellor entering this frame of reference will be keeping up with the story, asking questions to clarify, making tentative empathic responses to check his or her understanding, and being aware, as much as possible, of any inner feelings that result from being in relationship with the young person, much as in a relationship with an adult client.

What feels different is the absence of the reflective voice of the client: where adults may communicate an understanding of a psychological process during a session, young people normally do not. Neuroscience research into adolescent brain development tells us that the capacity for this type of reflection is in one of the last parts of the brain to develop and is not fully functioning until very late adolescence (Sebastian, Burnett, & Blakemore, 2008). Consequently, the counsellor working with adolescents will be especially attuned to all aspects of the client's means of expression in addition to verbal content, including body language, facial expression, tone of voice, eye contact (or lack of it) and any other clues to how the young person may be feeling, and will be the reflective voice in the relationship, always checking with the client that the sense of the feeling is correct (Box 18.5).

Box 18.5

The reflective voice with an adolescent client

A 13-year-old boy, who has been referred to a school counsellor because of his angry and violent behaviour, talks for most of the session about how great he is at doing almost everything, including daring feats such as jumping off of roofs, repairing his bicycle when nobody else could fix it, and frightening off boys much bigger than he was who were about to attack him. The counsellor listens with attention, although sometimes finding it difficult to find space in the narrative to check her understanding. Near the end of the session, she reflects that he is telling her that he is good at a lot of things. He looks at her in astonishment and says, 'No, I'm not!' The counsellor recalls for him what he has been saying during the session. He thinks for a minute and then says, 'Maybe I am.'

Issues of capacity, consent and confidentiality

When working with young children, the involvement of parents or carers will be an integral part, and it is normally they who decide to bring their child to therapy. With adolescent clients, it is not so straightforward. A young person's legal right to consent to – or refuse – therapy without the agreement of an adult varies throughout the world, and it is good practice to be aware of the law in the practitioner's own country.

Regardless of the rights that apply in individual countries, all nations aside from the USA and Somalia have adopted the United Nations Convention on the Rights of the Child (UNCRC; see www.unicef.org/crc), which enshrines a child's right to,

among other things, privacy, protection and participation in all matters that affect them, taking into account their degree of maturity. The UNCRC is person-centred in its values of trusting in the capacity of young people and ensuring that they have a voice, and that their views are taken seriously.

Where an adolescent has a legal right to agree to counselling and has capacity to do so, further discussions can take place on what degree of involvement parents or carers may have, based principally on the wishes of the young person and agreed by all parties. This may range from no involvement at all, or simply being aware that a young person is having counselling, to being included in counselling sessions. Confidentiality may be limited by certain factors, most importantly child protection concerns, but also such things that can be agreed in the initial contracting with clients and referrers. Holding the delicate balance between confidentiality and being person-centred in responding to all parts of the constellation of people that surround the client is an ongoing part of working with adolescents.

Research

Process and effective factors research

Within play therapy, Schmidtchen and Engbarth (1986) have indicated that the following therapist behaviours were most effective:

- empathy for client processes and reflection of feelings;
- being calm and relaxed;
- implicit help by arranging cues;
- personal commitment;
- overview on the therapy process and taking meta positions.

Research by Fröhlich-Gildhoff (2008) supports the effective factors findings of Grawe, Regli, Smith and Dick (1999; Grawe, 2004) – activation of resources, support in problem-solving, clarification and process activation – and adds a fifth factor for child and adolescent therapy: an increase of competences such as cognitive, motoric, self-regulating and emotional skills.

In his review of evaluation studies of humanistic counselling in secondary schools, Cooper (2009) found that young people rated 'talking and being listened to' over three times more helpful than other factors, including 'advice/guidance'. Although 'acceptance' on its own did not rate highly, 'talking and being listened to' implies a therapeutic context in which all six of the core conditions (Rogers, 1957) exist.

Outcome research

Two recent major papers present an array of outcome research for person-centred child and adolescent therapy. The meta-analysis of Bratton et al. (2005) identified 73 humanistic, non-directive play therapy studies, with an average effect size of 0.92. The review from Hölldampf, Behr and Crawford (2010) included 83 outcome

studies on person-centred child and adolescent therapy broken down to diagnosis as defined in DSM-IV and study design. They found that person-centred therapy was effective for a wide range of psychological problems in children and young people. In addition, a recent study by McArthur, Cooper and Berdondini (2012) found that school-based counselling, based on person-centred principles, brought about significant reductions in psychological distress and improvements in self-esteem.

Conclusion

As a client group, children and young people engage, process and communicate in the therapeutic relationship in ways that can relate to their particular developmental stage. Person-centred therapy with children and young people is therefore a specific area of person-centred work, as well as a major therapeutic approach in its own right that covers a comprehensive theory of the person and therapeutic processes towards wellbeing. Concept extensions such as interactive resonance are based on developmental psychology like attachment theory and schema theory. Person-centred therapy with children and young people is described in an array of text and edited books in major languages of the world, and is shown to be effective in extensive process and outcome research. Concepts from person-centred work with children and young people influence a wide range of everyday life issues around the globe, such as family life (Gordon, 1970), school climate (Aspy, 1972; Aspy & Roebuck, 1977; Cornelius-White, 2007; Rogers & Freiberg, 1994; Tausch & Tausch, 1991), violence prevention (Fröhlich-Gildhoff, 2006; Rosenberg, 2003) and emotional learning (Goleman, 1995; Salovey & Mayer, 1990).

Points for reflection

- In play therapy, how would you decide when it would be important to offer an interactive therapeutic relationship, or when a facilitative therapeutic mode would be best for clients?
- What process might you undertake to determine how best to attend to, and prioritize if necessary, the needs and expectations of both young clients and caregivers?
- Do therapists working with children and adolescents have a role in enforcing society's behavioural norms where those needs are in conflict with the young person's expression of their actualizing tendency?

Key readings

- Behr, M. (2012). *Interaktionelle Psychotherapie mit Kindern, Jugendlichen, Eltern und Familien* [*Interactive psychotherapy with children, adolescents, parents, and families*]. Göttingen: Hogrefe.

A comprehensive and practical guide to both facilitative and interactive therapy.

■ Behr, M., Hölldampf, D., & Hüsson, D. (Eds.). (2009). *Psychotherapie mit Kindern und Jugendlichen – Personzentrierte Methoden und interaktionelle Behandlungskonzepte* [*Psychotherapy with children and adolescents – person-centred methods and interactional treatment concepts*]. Göttingen: Hogrefe.

Includes classical, interactive and experiential methods and work with adolescents.

■ Cochran, N. H, Nordling, W. J., & Cochran J. L. (2010). *Child-centred play therapy. A practical guide to developing therapeutic relationships with children.* Hoboken, NJ: John Wiley & Sons.

A comprehensive resource that thoroughly teaches the theory, methods and practice of child-centred play therapy.

■ Cooper, M. (2009). Counselling in UK secondary schools: A comprehensive review of audit and evaluation studies. *Counselling and Psychotherapy Research*, 9(3), 137–50.

A review of the evidence on person-centred and humanistic school counselling with young people in the UK.

■ Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York: Brunner-Routledge.

Provides extensive and detailed information for creating therapeutic relationships with children and facilitating the play process.

■ www.a4pt.org

Website of the Association for Play Therapy, which promotes play therapy to advance the psychosocial development and mental health of all people.

■ www.playtherapy.org

The website of Play Therapy International, which offers reading, conferences and training.

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19
Couples and families

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This chapter discusses:

- How family therapy resources can be made compatible with the core conditions of the person-centred approach
- The higher level of client-centred therapist activity required by multiperson therapy
- A 'job description' or six practices that integrate Rogers' six conditions for effective therapy with the demands of a multiperson system

Person-centred couple and family therapy is built upon the dialogue between Carl Rogers' six conditions for effective therapy (1957) and the demands of a living multiperson system. Many contemporary couple and family therapists give Rogers partial credit for the heart of their collaborative, client-directed, dialogical, empathy-oriented, non-expert-centred approaches – see, for example, Anderson (2001), Sprenkle, Davis and Lebow (2009), Madigan (1994) and especially Moser and Johnson (2008). A person-centred approach, consistent with Rogers' conditions, may also adapt to the kind of reframing, active facilitation and awareness of contemporary relationship contingencies that have developed in the 70-year history of family therapy (O'Leary, 2008, 2012). The goal of person-centred couple and family therapy is to create an atmosphere in which couples and families are safe to be congruent, able to listen and show each other empathy and acceptance so that they can solve the problems that can be solved or recognize those predicaments that can only be understood and accepted.

Brief literature discussion

Many outstanding contributors to person-centred literature have written about couple and family therapy: Rogers (1961, 1972), Raskin and Van der Veen (1970),

Warner (1983, 1989), Barrett-Lennard (1984, 1998, 2005), Guerney (1984), Levant (1984), Mearns and Thorne (1988), Anderson (1989), Cain (1989), Snyder (1989) and Mearns (1994). Earlier writings did not emphasize the possibility of adapting the therapist's behaviour to the conditions of working with the differing demands of a wider system. The writing of Gaylin (1989, 2001) and O'Leary (2008, 2012) have focused on the particular applications of Rogers' conditions in the face of competing client claims for understanding and validation, as well as the objective challenges of individual and systemic development over time.

A bridge between the person-centred approach and the mainstream of couple and family therapy is provided by the work of Greenberg and Johnson in *Emotionally focused Therapy for Couples* (1988) and other work by Johnson (2004, 2008b) and Greenberg and Goldman (2008) (see also Box 19.1). At the centre of this experiential approach in work with couples is the identification of a frequently occurring pattern: one client who is quite expressive of anger and criticism, while the other partner tends to be withdrawn and uninvolved in the face of strong emotion. Emotionally focused therapists identify this pattern and model a substitute, which is the empathic tracking of the feelings of the most distressed client, translating angry accusations and negative labelling into an expression of core feelings and needs. At the same time, the therapist enlists the more withdrawn partner to bypass defensiveness in order to express feelings of caring, love and attachment.

Box 19.1

The person-centred approach and empirically supported therapies

There is no research specific to a person-centred approach to couple and family therapy. Recent literature on common factors in couple and family therapy (Sprenkle et al., 2009) indicates, however, that the core conditions of the person-centred approach are essential to the practice of all schools of couple and family therapy. Sprenkle and his fellow authors also remark, referring to Carl Rogers' research of individual therapy:

> Ironically, Rogers' research-based therapies don't qualify for lists of empirically supported treatments (EST's) today because the clients were not subjected to the kind of medical-model based assessment of their pathology that Rogers rejected as inconsistent with his approach … That a person-centred treatment cannot qualify for lists of EST's because Rogers' research did not focus on a specific medical model diagnostic category is an indictment of the methods used in determining which therapies qualify as EST's. (p. 20)

Emotion-focused couple therapy, close to the person-centred approach in its emphasis on empathy, experiencing and attention to emotion, has been validated as one of the two most empirically supported modalities of couple therapy (Johnson & Lebow, 2000). Empirically supported models such as functional

family therapy (Sexton & Alexander, 2003) also assume a client experience of empathy and acceptance as essential in their work with families of adolescents. A recent meta-synthesis of 49 studies of client reflections on couple and family therapy indicates strong support for qualities first identified by person-centred research, for example acceptance, warmth, listening to clients, non-judgement, transparency, respect and transcending usual therapist-client roles – that is, treating clients like equals (Chenail et al., 2012).

The person-centred therapist interested in couple and family work would be wise to consult the work of mainstream couple and family therapists, for example the *Journal of Marriage and Family Therapy* in the USA and the *Journal of Family Therapy* in the UK. Also indispensable, in our view, is the exhaustive research of John Gottman (1999), who has studied heterosexual couples for over 25 years and same-sex couples for 13 years (Gottman et al., 2003) through thousands of hours of videotaped interactions, physiological measurements under stressful conditions, and surveys of distressed and non-distressed couples followed over decades.

The postmodern therapy movement, expressed in the work of Goolishian and Anderson (1992) and Anderson (1997), reflects the privileging of each person's subjective reality in a spirit very close to the person-centred approach. They discuss the therapist seeking to understand rather than already claiming understanding, as Goolishian and Anderson (1992) have written. Narrative therapy (White, 2007; White & Epston, 1990) provides therapist language and postmodern support for key person-centred attitudes towards clients' initiative and identity separate from their problems. The postmodern questioning of language systems facilitates the kind of non-judgemental atmosphere in which clients can claim their own 'locus of evaluation' (Mearns & Thorne, 1988) and be free from predetermined roles – this may be particularly important in work with sexual minorities such as gay and lesbian couples (Green, Bettinger, & Zacks, 1996; O'Leary, 2012).

Regarding contemporary family therapy, David Bott has written 'Pragmatically, if we are seeking to humanize our practice and respond respectfully to families with a view to creating a context which empowers rather than subjugates, Rogers provides a clear, accessible and, above all, ethical position from which to do this' (2001, p. 375). In the same article, Bott has emphasized that family therapists can assume they have mastered the conditions of the person-centred approach without engaging their true complexity and full implications.

O'Leary, in *Counselling Couples and Families: A Person-centred Approach* (1999) and *The Practice of Person-centred Couple and Family Therapy* (2012), makes an explicit case for integrating the core ideas of the person-centred approach with the evolving development of couple and family therapy. It is this approach that we will present here, with the understanding that readers will decide which elements of couple and family practice are compatible with their own understanding of the person-centred approach.

Job description for a person-centred couple and family therapist – from internal and external points of view

Actively seek to understand and show acceptance of each person present

At the beginning of the therapy, the therapist welcomes each person separately and invites them to share reasons for being there. The therapist practises *multidirectional partiality* (Böszörményi-Nagy & Ulrich, 1981), that is, they do not *not* take sides, but establish their willingness to be a voice for all sides, understanding each as deeply as possible and acting as a trustworthy translator for all.

Internally, they consider all participants, silent or talkative, open with feelings or apparently guarded, to be doing the best they can in the situation.

The therapist actively reflects back what each person says, especially in the early sessions, unless doing so would interfere with clients' natural responses to each other.

It will usually emerge that one client will invoke more natural sympathy in the therapist than another. The therapist's task is to remain curious and open to the communication of the client who is harder to understand. It is important that they do not view one client as the one with the greater emotional needs and therefore relegate a partner, parent or child to the role of supporter, adversary or bystander. For example, a wife who feels emotionally unsupported is no more the client than a husband who appears unresponsive or rigid; a child who feels criticized is not a more important client than a parent who is absorbed by disapproval and anxiety. This is one of many examples of multidirectional partiality in action: not preferring one way of being over another.

A useful technique for the therapist is to ask permission to understand each perspective without joining into implied or explicit disapproval of others. 'I am going to be listening to the parent side of this thing for a while. Do you understand that I will be listening, in a few minutes, to the kid side of this, too?'

The therapist shows the ability to understand and accept the couple or family as a whole. Couples and families in therapy often feel shame or expect to be seen as foolish – 'How could a couple get into such a terrible situation?' – and are sensitive to any perceived judgements on the part of the therapist and very relieved by the therapist's '*non-anxious presence*' (Friedman, 1991) in the face of their dilemma. The therapist may sometimes describe all the sides in a conversation – 'interspace reflection' as Ned Gaylin describes it (Gaylin, 2008). For example, 'When Claire expresses her longing for more independence and time alone, Jonathan feels unwanted. Claire ends up feeling trapped while Jonathan feels pushed away even though neither of you intends to control or distance the other.'

Provide structure for the sessions, paying particular attention to the first and final sessions in a course of therapy, as well as to the conditions of each session's beginning and ending

Couple or family therapy with an inactive therapist can be unhelpful, even harmful, and has no support in research on couple therapy (Gottman, 1999). Structure, however,

does not mean directiveness (teaching, advice giving, interpreting) (Butler & Bird, 2000) or taking a hierarchical position, but must always be in the service of each client's congruent and self-directed participation in dialogue. The resolution of this apparent paradox is the life-long task of the person-centred couple and family therapist.

Structuring is essential for the following reasons:

- Clients can be caught up in well-established reactions to one another rather than listening, in the moment, to the feelings that are at the core of the other's alienation.
- Without structuring, the person most able to talk and express feelings will do so for most of the therapy hour, even while experiencing distress that their partner remains withdrawn and/or unreceptive.
- Couples and families will rarely return to a counselling experience marked by chaos, confusion or undirected rage.

The beginning of a course of therapy

Clients are asked about their purpose in being there and have the opportunity to ask about what the therapist will do and not do. The therapist will clarify expectations such as:

- that each person will have a chance to speak;
- that the therapist will sometimes interrupt in order to facilitate dialogue with others in the room;
- that each person has the right to disagree, be angry, be disappointed or otherwise share negative feelings;
- that insults or non-verbal gestures of contempt are, however, incompatible with therapy.

Managing these expectations is a shared task of everyone in the room. In describing this structure, therapists may invite all participants to comment if they seem to them too intrusive or to get in the way of their working on problems in their own way.

The beginning of each session

The therapist will usually begin the session by asking all clients what they would like to focus on and facilitating a consensus about where to begin while taking responsibility for bringing up other subjects or, at end of session, acknowledging they were not addressed; these can then be marked for the beginning of next session if they remain a concern for the person who suggested them. If the therapist does not do this, one or more clients will, by default, find themselves in a dialogue not of their choosing. Unlike in small group encounters, this process usually requires little time.

The end of each session

The therapist will wisely reserve the last 5 or 10 minutes for their own use in summarizing the events of the session, checking that someone has not been left unexpectedly

hurt or disempowered, acknowledging agreements reached and issues unresolved, and deciding if and when to schedule a next session. It is most important that the therapy hour end with the therapist's active facilitation of clients observing the process rather than re-engaging in highly emotional issues that could leave clients in a state of frustration or futility. It is sometimes most meaningful to ask each member to name something they appreciated that others present offered during the session. Client reports on couple and family therapy quality indicate a desire to increase family cohesion and understanding (Chenail et al., 2012).

The last session of the therapy

If possible (although clients sometimes leave therapy before this can happen), the therapist will use the last session to invite a process-oriented discussion. What is different? What cannot be translated into change at home? What has been resolved? What remains unresolved? What change in each person do individual clients wish to be acknowledged? These questions make explicit Rogers' sixth condition that emphasizes clients' experiencing of the presence or absence of facilitating elements in the therapy.

Ask for, clarify and refer back to each person's purpose in being in the session

Family therapy literature emphasizes the importance of questions: not questions seeking information for the expert therapist's mysterious use, but questions that encourage client reflection or that open bridges across the divide of *blame/defend* that often plagues relationships. Questions that might be intrusive in individual sessions may be welcomed by clients feeling unable to speak congruently in repetitive cycles of blame and discouragement.

- Whenever clients become anxious, argumentative or lost in a monologue, reference to each person's stated reason for being there enables them to become present to the dialogue at hand. For example, the therapist may ask: 'Is this it? Is this the kind of dreadful moment you were describing?'
- Frequently, a teen or a reluctant partner will not be willing to answer the question explicitly. The therapist may venture an empathic guess or reassurance about their right in their own time to say what they want or simply find a way to acknowledge their willingness to bring them into the conversation when they are ready. For example, a therapist may say to a teen who shows a dramatic reluctance to participate: 'I will ask you questions from time to time, but you don't have to answer, OK? Let me also ask this: if you disagree with something that is said or have something to add, will you let me know?' By so doing, they may release a parent from forcing a child to participate along with the tension such an attempt would likely produce.
- The question '*What do you want?*' or variations may be particularly helpful when, as is common, anger is expressed in the session. 'The counselor's presence matters in the expression of anger. He puts it in context, punctuates it and makes sense

out of it. It is not just anger expressed but anger, which is expressed in a counselor's office' (O'Leary, 1999, p. 20) A therapist may ask, 'What do you really want to have understood right now?', 'What are you looking for from your partner when you feel so frustrated?'

Sustain the conviction that each person is attempting to actualize himself; do not try to change anyone

When couples and families find an atmosphere in which they can be both accepted and congruent, they often do find a solution that, although not what the therapist might have chosen, lets them move to the level of problem-solving or acceptance of an immutable predicament. The therapist, working as a translator finding common goals in the middle of competing positions, is part of the client team looking for new possibilities. They do not need to urge, force, pressure or otherwise talk anyone into change. The therapist's noticing and commenting on shifts in language and behavior allows the system to restore its ability to solve problems and change. The conviction of an actualizing tendency in action allows the therapist to be an engaged participant rather than 'urgent, anxious, over-responsible and pessimistic' (Duncan, Hubble, & Miller, 1997).

- The therapist keeps the problem on the table without judging (Madsen, 2007).
- The therapist *slows down the conversational tempo* so that clients can become observers of their own and their intimates' change in words as well as tone.
- The therapist also *addresses the listener(s) regarding their responses to the speaker*: 'You have been listening without moving for several minutes. Are you ready to share what is happening with you?'
- Sometimes a question such as 'What's different?' facilitates client reflection either on possible new initiatives or reasons why they feel unable to take new initiatives.
- They *observe difference in clients between sessions and invite inquiry into what created the change* in words, non-verbal behavior and felt atmosphere. 'Am I right to think that something different has occurred between you this week?' This kind of question, asked about negative as well as positive change, allows clients to pay close attention to their relationship as something evolving rather than a static, unchangeable entity.
- The therapist responds to any moments in the dialogue in which one or more persons says something that varies from a static position.

For example, a husband in a terrible impasse about the possibility of his marriage being at an end said: 'I asked you about that, but you hung up on me.' His wife replied, 'I didn't hang up on you. I thought you hung up on me.' The therapist aware of a significant moment asks: 'Did I hear that correctly? Have both of you been living with the thought that the other hung up on you?'

Exercise a teaching function

Relationship therapy is affected not only by emotional responses between persons, but also by clients' understanding of the many cultural and developmental factors that influence their loved ones' words and actions. Negative feelings are sometimes the result of misdirected expectations. The therapist needs to be aware of the many objective pressures impinging on a relationship while staying faithful to the empathic reflection of each client's experience. Mentioning conditions that have a role in a predicament shows compassion for clients and acceptance of the reasonableness of their plight. In his book about couples, Carl Rogers deplored the lack of good literature for couples and spoke with gratitude about a physician who had given his wife and him needed information and useful questions about sex (Rogers, 1972).

The following conditions, among many others, put pressure on members of a couple that can cause frustration, resentment and outright blame of the other person:

- financial change for better or, especially, for worse;
- differences in families of origin;
- different gender socialization;
- unexpected illness;
- ageing;
- the birth of a child or children;
- special needs in one or more children;
- a change in one person's sexual physiology;
- homophobia and heterosexism, internalized as well as external.

The authors believe that it is impossible to do useful couple or family therapy without attention to developmental issues: for example, the time after a baby is born is almost universally experienced as a time of difficulty and loss, even while a couple rejoices in the presence of an adored and wanted baby. The therapist does not interrupt client sharing, or try to neutralize a client's strong feeling. However, as an alternative to the rigid accusations of selfishness and non-caring frequently expressed by new parents, they may raise the possibility of mutual loss and unexpected disappointment or suggest resources such as Gottman and Gottman's *And Baby Makes Three* (2007).

Therapists may share experiences and offer perspectives relative to the presenting problem; they are not experts offering a solution but participants in a group pursuing a change that leaves everybody respected. Many clients request 'homework' or readings, and, like Carl Rogers in his classes (1969), the therapist can make resources available such as communication exercises (Stuart & Jacobson, 1987) or readings on relationships, for example Susan Johnson's *Hold Me Tight* (2008a), or information based on research, for instance Gottman and Silver's *Seven Principles for Making Marriage Work* (1999).

Practise consistent non-defensiveness, which allows a therapist to work in a relaxed way for client goals and create the emotional ground for deeper client expression

Moments when clients challenge the therapist or (more rarely) are upset with them can be seen as gifts, great opportunities for client learning and growth. *When the therapist is not defensive in these moments, clients can feel safe to speak frankly about what is most important to them*. In so doing, they may feel able to risk speaking openly and clearly to their loved ones.

Sharing information about one's own humanity can occasionally be useful; denying or concealing this humanity is always a barrier to the goal of being helpful to clients in relationship. Every therapist is a person who has been a good and not good partner, friend, son or daughter, brother or sister, father or mother. Like others, they can get lost in fixed positions and call them their true feelings. They can harden suddenly in stubbornness or in an exaggerated sense of being the injured party. A therapist can also know what it is like to soften and change if allowed a glimpse of openness or vulnerability in a loved one.

In practising non-defensiveness, the therapist notices his own tone and attitude as well as the clients' non-verbal responses. 'I just became aware I was trying to talk you into listening to your wife more. Did it sound that way to you?' 'I think what I just said must sound very male to you and that I may have joined your husband without realizing it. What do you think?'

The therapist can sometimes bring humour into a situation without making light of anyone's words or actions except her own. 'Do you think I am doing a very good job as a facilitator right now?' may sometimes bring laughter into a situation that, moments before, seemed only hopeless.

Offering consistent written opportunities for clients to give reactions and feedback about sessions may help. The use of brief instruments such as those found, for example, at www.talkingcure.com have been shown to increase the positive effects of therapy and also to put Rogers' sixth condition into operation. The client event in Box 19.2 illustrates the way in which this approach attempts to offer structure that allows for client ownership of the therapy.

In Box 19.2, the therapist's work was to articulate the feelings of each partner so each could be heard on their own terms rather than cancelling each other's needs out by competing claims. Could their fears that they would have to lose each other be spoken without flooding the conversation with defensive posturing and claims to be able to do without the other? The therapy included reflection on the whole history of their marriage: what they had weathered before and what strengths had seen them through difficult times. They were able to admit that their habits no longer included activities about which they both were enthusiastic; they had to acknowledge areas in which they would never agree, like requests for money from one of Louis's sons or why Helena had to be the last one to leave her school.

Box 19.2

Case example: rediscovering love underneath the events of a long marriage

This story focuses on a couple in relation to a third entity, in this case, Louis's bowling team. It could be about a couple divided because of relationships with children, family of origin, work, religion or many other external pressures on a relationship.

This African-American couple, married for 23 years, were divided by a dozen unresolved issues, their incompatible work schedules and especially Louis's intense commitment to a championship bowling team that filled most of his weekends, some evenings and many unscheduled times, taking priority over any plans Helena and he might have. 'I'm sorry, honey,' was a deadly refrain that made Helena feel alone and unimportant.

Warm, humorous and gentle in speech together, they were as good to each other as friends can be, but each felt uneasy about the state of their life as a loving couple. They had weathered many storms, as all people who live long together must do; but the storms had left much unrepaired and their conversations were polite and distant. Louis had had disappointments in his career until he found work in transportation that demanded long hours and used up his social energy. Helena was the kind of educational administrator no school can do without, but was often not at home when Louis was and had to focus on rest when she was home. Their intimate life had been disrupted by illness many years ago, which, although resolved, had left them both so tentative in seeking sexual contact that they avoided each other, as well as conversation about what had happened to them. Louis's attention was also divided by the needs of his grown children from another marriage who had never lived with them and were never completely at ease with Helena. They came to therapy able to talk, but silence on important matters lay thick between them.

The couple gradually tackled the struggle between Louis's loyalty to the team and to his wife. Helena showed concern for Louis's deep investment in his team while having the courage to say that she thought his marriage should be more important. Louis was able to articulate how the team filled needs deeper than recreation, while also acknowledging that he had often been a man leaving his wife alone and unbefriended on long weekends. Louis now made more time for Helena during what had formerly been 'team time', and Helena was able to make modifications to her work schedule. This simple solution would not have been real without exploring the complex emotions each client had about loving and being loved, influence and control, individuality and togetherness.

The couple was eventually able to converse about their abandoned sexual contact and to unravel the hurts, fears of hurt and misunderstanding that kept them from physical closeness. Listening to one another about easier matters paved the way for conversation about the most intimate.

The stages of this therapy were as follows:

- Facilitating Helena's choice to invite Louis into the therapy, balancing the fear of rejection if he refused to attend with the cost of living with the undiscussed status quo. The therapist validated both sides of this truth rather than take a position on what she should do.
- Facilitating empathic listening to both persons' experience of the marriage, allowing each an equal turn to describe their own internal frame of reference – about the issue at hand, about Helena's feeling second in importance to the team, and about the many other issues that were inevitable over a long marriage.
- Each member of the couple trying new ways to engage and converse at home supported by the safety of therapy sessions in which to talk about the difference between what one person intended and the other person experienced.
- A technique – telling the story of their relationship over two sessions (Gottman, 1999) – that allowed them a new perspective on their current difficulties in the context of past hurdles.
- The therapist asking whether or not they want to attempt conversations neglected at home and gradually facilitating the discussion of their sexual relationship with less and less blame, fear and discouragement.
- The couple finally facing the question 'Can Helena ask Louis for time together ordinarily blocked by Louis's team commitments?

  Louis: You've just got to trust me. And I've just got to come through and be there for you.
  Helena: You're right. I have to do that. I don't know when but I have to do that.
  Therapist: Yet it feels very tender. Like: if he says no it could break your heart.
  Helena: Yes it is tender. If he says no, I don't know what I'll do.
  Louis: I've just got to show up and be there for you.

In fact, Louis found a different path and himself asked Helena to do things during team time rather than leave the responsibility to her.

The therapy facilitated safety for conversations that had grown rusty and communication that had been blocked by years of unspoken feelings and thoughts. Each member, feeling more heard and more safe, was able to be more understanding of and flexible with the other.

Conclusion

A person-centred couple and family therapist is a lifelong learner, educated best by contact with clients and supervisors familiar with couple and family life. Rogers' six

conditions for therapy offer a true north as on a compass: whatever enhances the clients' experience of empathy and unconditional acceptance creates a useful direction for therapy; whatever detracts presents a confusing distraction to therapy. Rogers' conditions become alive by attention to active facilitation of an encounter between emotionally intense participants. Therapist awareness of common patterns of couple and family life deepens clients' trust in their own abilities to navigate the inevitable troubled waters.

Points for reflection

- If you were in therapy with your family or partner, how would you want therapists to be different from if they were seeing you individually?
- What would be most important to change in your approach to seeing families and couples as distinct from individuals? What would be most important to retain?
- What is the advantage of seeing a couple together rather than individually? What perceived disadvantages can keep people away from couple meetings? What can the therapist do to facilitate good effects and facilitate safety from bad effects?

Key readings

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- Greenberg, L. S., & Goldman, R. N. (2008a). *Emotion-focused couple therapy: The dynamics of emotion, love and power*. Washington, DC: American Psychological Association.

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20
Older adults

ALLYSON WASHBURN AND SOFIA VON HUMBOLDT

This chapter discusses:

- How adopting a life course perspective can help the person-centred therapist understand old age not as a separate period of life, but rather a part of a life-long developmental process
- The developmental tasks of later life that provide opportunities, for example, for older adults to experience gerotranscendence
- The presumptions and biases about older adults that therapists who work with them might have, and the need to develop a deep appreciation for the paradoxes inherent in the ageing process
- Specific ways to apply the core concepts of person-centred psychotherapy and counselling with older clients, including those with mild cognitive impairment and dementia

A United Nations' report for the 2002 World Assembly on Ageing concluded that world population ageing is unprecedented in human history, is pervasive in its impact on persons of all ages, and has profound implications for many facets of individual and collective life. In 2000, one in every 14 persons was aged 65 or older; by 2050, one in every four persons living in the more developed regions of the world is likely to be 65 or older, with Europe having the highest proportions of older persons. This massive demographic shift will present challenges, as well as opportunities, for persons currently in or entering the human services professions. Midlife and younger cohorts, who tend to be more psychologically minded and more familiar with psychological services than today's older adults, will likely contribute to an increased demand for therapists and counsellors over the next few decades as they age.

The premises that underlie client-centred psychotherapy and counselling – namely, reliance on a 'constructive actualizing tendency of the human organism as a motivating force' and a focus on releasing 'growth and development rather than thinking of [psychological problems] as a pathology to be cured' (see, p. 24) – are as applicable to work with persons in their seventh, eighth and ninth decades of life as with those much younger. In essence, the person-centred approach is a holistic, organismic theory that regards the individual as an integrated whole (Sanders, 2007). Instead of focusing on interpretation, the person-centred therapist seeks to understand older clients from within their own frames of reference and individual ways of experiencing, and to find ways to promote growth and development with, rather than for, them (Pörtner, 2008).

Similarly, the conditions that are both necessary and sufficient to provide a 'facilitative growth-producing psychological climate' (see p. 25) – that the therapist be an empathic, congruent person who cares for and prizes the client – are the same for persons of all ages. This being so, with the right conditions, the older client can flourish and realize his or her full potential in order to become fully functioning and psychologically well-adjusted (Sanders, 2007).

What, then, is different about therapeutic practice with older adults that warrants a separate chapter in this volume? The developmental tasks of persons in their last years are arguably different from those of the young. As the case of 83-year-old Charlotte, a retired teacher who was recently widowed, suggests, many of the psychological problems older adults experience are perhaps best described as existential.

The first time that Charlotte came to therapy, she seemed at once distraught and distant. Her children were concerned because of her increasing forgetfulness, lowered self-confidence, and physical and social withdrawal during the past year. She was less autonomous since her husband's death, presenting increased difficulty handling her household tasks. She was afraid of going out of the house for simple shopping and expressed her worry: 'My neighbours think that I am lazy.' Charlotte had begun doubting her perception of the world around her. 'Sometimes people speak rapidly to me and I do not really understand what they saying or what they want from me. It really makes feel that I don't belong here.'

Charlotte's children expressed they would like her to move to an assisted-living facility. In therapy, her mild depressive mood was prominent. She also showed irritability and mild anxiety. She expressed distress about the possibility of moving from her home and felt despair about her husband's death as well as her further cognitive decline. She had begun to lose hope that she would regain her abilities and that her future would be better.

Life course perspective on ageing

Coming full circle means coming to recognize the circle of life, which is compensation for finitude and a glimpse of what lies beyond. As the Celtic proverb puts it:

> 'Make time a circle, not a line.' When we regain this vision, vision of the great circle of life, successful aging becomes conscious aging. (Moody, 2009, p. 76)

Gender, ethnicity and conditions of living throughout the life course, such as social class and education, are important determinants of one's experience in the last years of life. An implication of this life course perspective is that the variability among the members of a cohort will increase as they age. Quality of life in old age is a culmination of a lifetime of individual choices, as well as differential access to resources and opportunities. Genetic factors, accidents and illness and disease also affect the life course into one's later years.

A number of current medical models, for example the free radical and autoimmune theories of ageing, view age-related changes and death as a result of disease. In contrast, gerontologist Harry Moody (2010) defines *normal ageing* as an 'underlying time-dependent biological process that, although not itself a disease, involves functional loss and susceptibility to disease and death' (p. 55). According to the *compression of morbidity* view, an optimal old age, and one that is increasingly possible, is an old age with minimum sickness or frailty, and for those seeking successful, or productive, ageing, as described in the quotation at the start of this section, 'as much like youth or midlife as possible' (Moody, 2009, p. 71).

The physical changes that accompany ageing are, however, many and marked and, for some, debilitating. Changes in cognitive functioning also appear as we age, although the slowing of response times, for example, that appears to be normative is difficult to detect outside the laboratory. Age itself is the principal risk factor for dementia, however, and 43 per cent of Americans aged 85 years and above have Alzheimer's disease, the most common type of dementia (Alzheimer's Association, 2011).

Indeed, even rigorous adherence to guidelines for health maintenance and wellness promotion cannot prevent the inevitable losses and frailty of advanced age. Compression of morbidity is not an option for many older adults, so many instead accept decline when it comes, compensating for and adapting to it in a version of successful ageing termed *decrement with compensation* (Moody, 2009) or *selective optimization with compensation* (Baltes & Baltes, 1990). With losses in functional capacity, many older adults seek new ways of accomplishing things that have become difficult, just as when they were younger, and may also narrow the scope of the capabilities they seek to maintain and optimize to those they find most useful.

Moody (2010, p. 5) suggests that we can 'most fruitfully understand old age not as a separate period of life, but as part of the total human life course from birth to death'. People within a culture share expectations about the appropriate age for life events to happen, but norms are changing, particularly for mid and later life. A life course that is 'more fluid and variegated than age-graded and lockstep' (Moen, 2011, p. 27) requires that we evolve more age-integrated communities where older adults can participate to the fullest extent possible in civic life. At present, opportunities for older adults to address what McClusky (as cited

in Findsen, 2006) has termed *coping* and *expressive* needs tend to be plentiful, but their *contributive* and *influence* needs are less often met – very much a loss to the commons.

Some cognitive functions – for example, those involved in social functioning (Washburn, Sands, & Walton, 2003) – appear to improve with age and can compensate for those that may evidence decline. Intellectual and physical engagement have been found to increase the cognitive function of older adults and to provide an opportunity for social interactions and civic life, as well as to develop a sense of personal meaning (Bassuk, Glass, & Berkman, 1999; Park, Gutchess, Meade, & Stine-Morrow, 2007; Wilson et al., 2002). Charlotte, from our example above, would like to return to a learning environment where she could interact with children again. 'I would really like to stay in the kindergarten and progress to a volunteer position in the community school. When I tell children stories that I invent, I am astonished with questions that really make my mind work to find swift answers.' This challenge could become the opportunity to bring Charlotte a sense of worth and belonging.

Psychological growth and development in later life

> A human being would certainly not grow to be seventy or eighty years old if this longevity had not meaning for the species. This afternoon of human life must also have significance of its own and cannot be merely a pitiful appendage to life's morning. (Jung, 1933/2005, p. 112)

Stage theories of human development track the life course, with Erik Erikson's conceptualization of eight psychosocial crises to be revolved over one's lifetime arguably the most influential. Three crucial stages and the strengths that emerge from the clash of their characteristic syntonic and dystonic tendencies are 'hope from the antithesis of *basic trust* vs. *basic mistrust* in infancy; fidelity from that of *identity* vs. *identity confusion* in adolescence; and care from *generativity* vs. *self absorption*' (Erikson, 1982/1997, p. 55). In later adulthood, we begin reflecting on issues of generational constancy and change, our own biological finitude, and the meaning of life – the unique endeavours of the 'afternoon of human life' (Jung, 1933/2005, p. 112). The dominant antithesis of old age is *integrity* versus *despair* through which 'the life cycle weaves back on itself in its entirety, ultimately integrating maturing forms of hope, will, purpose, competence, fidelity, love, and care, into a comprehensive sense of wisdom' (Erikson, Erikson, & Kivnick, 1986, pp. 55–6).

Box 20.1 summarizes the key properties of wisdom, which developmental theorists Baltes and Staudinger (2000, p. 122) define as 'an expert knowledge system concerning the fundamental pragmatics of life'.

Recognizing that the *oldest-old*, those aged 85 and above, increasingly face new demands and daily difficulties as the body loses its autonomy, Joan Erikson

(1982/1997) added a ninth stage to the initial eight to clarify these challenges. Previously resolved crisis points are revisited, and whereas in earlier life the syntonic elements of the stages – for example, generativity – were a source of strength, in the ninth stage strength comes from overcoming the dystonic elements – stagnation. Charlotte stated, 'You see, since my husband passed away, I don't know what I am doing here any more; I took care of him, through the day … I feel now like a drifting boat. I try to keep my routine. That's how I strive to be alive.' Older adults often experience frustration and sense that nothing is happening (Gendlin, 1997), but, according to Erikson (1982/1997), with their evolving perspective comes resilience. Charlotte mentioned, 'I am aware of my limitations but still I want children in the kindergarten to trust me. I do not want to withdraw from their company. I feel alive when I am with them.'

Box 20.1

Properties of wisdom

- Wisdom addresses important and difficult strategies about the conduct of meaning and life.
- It involves a truly superior level of knowledge characterized by:
  - an extraordinary scope, depth, and balance;
  - an understanding of life's uncertainties.
- This knowledge is used for the good or *wellbeing* of oneself and others.
- Wisdom is difficult to achieve and specify, but is easily recognized when manifested.
- Wisdom involves a perfect synergy of mind and character, knowledge and virtues.

Joan Erikson (1982/1997) suggested that successful resolution of the ninth stage leads to *gerotranscendence*, which Lars Tornstam (2005) has characterized as forward and outward development along the three dimensions outlined in Box 20.2. The life cycle nearly complete:

> we are called to become more and more human; we must discover the freedom to go beyond limits imposed upon us by our world and seek fulfillment. In the beginning we are what we are given. By midlife, when we have finally learned to stand on our own two feet, we learn that to complete our lives, we are called to give to others so that when we leave this world, we can be what we have given. (Erikson, 1997, p. 126)

In this view, by transcending our selves, we grow into our death.

Box 20.2

Gerotranscendence

The cosmic dimension

- *Time and childhood:* transcendence of borders between past and present; childhood is sometimes interpreted in a new, reconciling way.
- *The connection to earlier generations:* the individual link (the life) is less important than the chain (the stream of life).
- *Life and death:* fear of death disappears, and a new comprehension of life and death appears.
- *Mystery in life:* the mystery dimension is accepted.
- *Transcendental sources of happiness:* rejoicing in the macrocosmos in the microcosmos – the small and commonplace; this is often related to experiences in nature.

The dimension of the self

- *Self-confrontation:* discovery of the hidden aspects of the self – both good and bad.
- *Decrease of self-centredness:* removal of the self from the centre of one's universe, or the struggle to establish a level of self-confidence that feels appropriate (if there is no self-importance to transcend).
- *Development of body transcendence:* care of the body continues, but obsession ends.
- *Self-transcendence:* a shift may occur from egoism to altruism.
- *Ego-integrity:* a realization that life's jigsaw pieces form a wholeness.

The dimension of social and personal relationships

- *Changed meaning and importance of relationships:* more selective and less interested in superficial relationships, with an increasing need for periods of solitude.
- *Role-playing:* an urge to abandon roles, while also understanding their necessity at times.
- *Emancipated innocence:* a new capacity to transcend needless social conventions.
- *Modern asceticism:* an understanding of the petrifying gravity of wealth and the freedom of asceticism, having just enough.
- *Everyday wisdom:* a reluctance to superficially separate right from wrong, thus withholding from judgement and giving advice; increased broadmindedness and tolerance.

Personhood in later life

> Let us recognize ourselves in this old man or in that old woman. It must be done if we are to take upon ourselves the entirety of our human state. And when it is done we will no longer acquiesce in the misery of the last age; we will no longer be indifferent, because we shall feel concerned, as indeed we are. (de Beauvoir, 1970/1996, p. 5)

Western cultures tend to be ageist, and stereotypes and misconceptions about older adults – however benign – are widely held and little examined. Contrary to what de Beauvoir (1970/1996) suggests, we tend not to see ourselves in an older person. In presenting the consensus guidelines for psychological practice with older clients, the American Psychological Association (2004) lists first those regarding attitudes. Counsellors and therapists are encouraged to recognize how their own attitudes and beliefs about ageing and their personal reactions to older persons may affect their clinical practice.

A teaching strategy that one of the authors (AW) developed to help prepare graduate students for working with older adults is to challenge them to confront their own old age. One assignment asks them to imagine an encounter with their inner elder (Box 20.3). Another requires them to imagine their life at age 75, and then at 85, and describe the supports they will need from their community and the larger society, taking a broad, integral approach that considers their physical, psychological, spiritual/existential, social and economic *wellbeing* at these ages. Students report that these assignments are challenging, interesting and transformative as they come to come to see themselves in older people they encounter.

Box 20.3

Meeting your inner elder

The concept of an inner child was popularized in the 1970s and refers to the childlike aspect of our selves. We are urged to care for our inner child, as we would our own children, and to afford it opportunities for expression in our lives. A more recent development in thinking about the constellation of entities that reside within us is that of our inner elder (Wacks, 1994).

Imagine that you are encountering your inner elder for the first time. Describe this encounter. How does this being strike you? What are your impressions? Engage in a dialogue with your inner elder. What do you learn? And, importantly, what more could you learn? Finally, is this encounter something that you might want to experience again? and again? Why?

Recognizing the personhood of older adults with dementia can, however, be difficult. Kitwood (1997), whose research focused on the subjective world of demen-

tia, identified a cluster of psychosocial needs – comfort, attachment, inclusion, occupation and identity – that together manifest as the central need for love. He urged caregivers and therapists to understand dementia in a way that integrates physiological, social and personal factors to explain and treat the behaviour associated with the illness.

Charlotte very pointedly said, 'all the doctors, they feel pity for old people and they don't listen to me …'. She also wished her children would slow down and listen to her when they visited, but they were always in a rush and did not make time for her. Instead, they brought to her attention things that she had forgotten or that she must do. 'Imagine how you would feel if you could not trust your own perceptions? You see, it was not easy for me to feel that something was wrong with me and that they were observing me and reminding of my weak spots.' She continued: 'I feel irritated because they make me feel like a child.'

Therapists need to develop effective communication skills that accommodate the person's cognitive limitations while respecting their sense of personal competence and meaning (Kitwood, 1997). The primary goal of dementia care is to maintain the integrity of the individual's personhood, where this is understood as existing 'in the context of relationship and social being' (p. 8), and where the 'loss of self' and the 'loss of meaning' are not assumptions.

A gracious nursing home resident reminded one of the authors (AW) of this as she screened him for a clinical trial of donepezil (Aricept) for moderate to severe Alzheimer's disease. It was at first challenging to engage this frail man who then missed nearly all of the questions on the screening test, including those for orientation to time and place. For the last, difficult item requiring him to write a complete sentence, he first asked how to spell her name. With much effort and a tremulous hand, he wrote – and then translated for the author when she could not read his writing: 'Allyson, I am very pleased to have met you.'

Therapeutic practice with older adults

The new Pikes Peak model for geropsychology (Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010) defines the foundational competences for clinical practice with older adults, including skills related to ethical and legal issues – capacity/competency, end-of-life decision-making, abuse and self-neglect – cultural diversity and self-reflection. Whereas these skills, as well as an understanding of the social and psychological dynamics of the ageing process, are important, critical for the person-centred therapist are the attitudes that he or she brings to the encounter with the older adult. Psychotherapist Marlis Pörtner, in *Being Old is Different: Person-centred Care for Old People* (2008), maintains that 'Working in a person-centred way is *more an attitude than a method*' (p. 19, original emphasis).

As Sanders (2007) reminds us, the three essential conditions – empathy, unconditional positive regard and congruence – for a facilitative therapeutic relationship, as well as for healthy growth, are 'attitudes to be held, not skills to be assembled and

practiced' (p. 15). When working with older adults, therapists must understand that greater than the fear of not being understood is the fear of being *mis*understood by the therapist. Using the case of Charlotte, the following discussion explains how the core conditions, or attitudes, of person-centred therapy create an 'affirmative facilitative climate' (see p. 25) for work with older adults.

Empathy

A core competency in the practice of person-centred therapy, empathy requires the therapist not only to accurately perceive the internal frame of reference of the client – and clearly convey that understanding – but, at its most evolved, to accept 'the person in her possibilities … "being open to being surprised, being kept awake by an enigma"' (Schmid as cited by Freire, 2007, p. 196). Many older clients grapple with the existential concerns of a life that is waning. For the therapist who is intensely attending to the expressed and intuited feelings of the older person comes an opportunity, with the client, for deep learning about human life near the end of life.

Charlotte's friends told her that she should get on with life after her husband died. She felt that they did not understand her need to grieve and talk about the difficult circumstances of her husband's death. Older adults yearn to be understood. The many daily worries, ruminations, all the 'shoulds' and 'ifs', are often a frantic effort for older adults to make sense of their lives. As mentioned above, when working with older adults, therapists must understand that greater than the fear of not being understood is the fear of being misunderstood by the therapist. For these individuals, person-centred therapy can facilitate a secure and reassuring environment.

In practice, what Brodley (2001, p. 17) has termed the *empathic understanding response process* is 'not a technique, but rather a process and an attitude … "trying to grasp the meanings that the client seems to intend to be understood by the listener"' (see Chapter 11). The therapist's 'genuine empathic acceptance' (Mearns & Cooper, 2005) reassures the anxious client, dissolving alienation and fostering the self-empathy needed for healing and growth. For some older adults, however, a process-directive approach may be more therapeutic. Rather than reflecting back in broad terms the felt experience of the client, the therapist, for example, selects what is most striking and poignant from what he or she is communicating and examines this further using different forms of empathic response: understanding, evocation, exploration, conjecture and interpretation (see Chapter 11).

Charlotte told the therapist 'My daughter does not trust me to care for my grandchildren alone. She says that if there was an accident, I would not be able to deal with it.' She relates, 'On the way to therapy, I saw a little boy explaining to his younger sister that she should be careful about petting a dog. All of a sudden, I felt so sad and reviled because I could not do the same with my own grandchildren. In fact, I'm less worthy of confidence than a little boy.' And then, she asked: 'Do you think I am still trustworthy?'

Charlotte's reaction was an opportunity for a therapeutic process of evocative unfolding of her emotions whereby she was encouraged to re-experience the situation and the reaction, to examine the connections between the situation, her thoughts and her emotions, and then finally to arrive at the implicit meaning of the situation – powerlessness, perhaps – that made sense of her reaction. When Charlotte indicated that she lacked confidence, she needed empathic affirmation from the therapist, who had to genuinely accept her and both understand and normalize her painful and debilitating experience.

For older clients with mild cognitive impairment and dementia, both Freire (see Chapter 11) and Pörtner (2008) recommend the use of Prouty's Pre-Therapy, which expands the empathic method to re-establish and strengthen contact functions. With *body reflections*, the therapist may gently mirror the nervous movements of the client – 'Your foot jiggles up and down' – to better understand and reflect what he or she might be feeling. As with a reflection of feelings in classical person-centred therapy, contact reflections are not a technique to be perfunctorily applied.

Older adults often feel they are seen as asexual and useless, which can deeply affect their self-esteem. Charlotte asked: 'Do I look good?' Saying this, tears came into her eyes while she looked down at her skirt and smoothed out some wrinkles. The therapist reflected Charlotte's facial expression: 'There are tears flowing down your face. You look sad.' Charlotte's expression then changed to one of concern, and the therapist followed with: 'You look worried.' By using facial reflections, we make possible affective contact with the client. Charlotte got up and walked towards the window. The therapist reflected her movement by saying, 'You walk a bit. We'll walk together.' Then, Charlotte expressed: 'Thank you, Sofia. For a change, I'm not feeling so lonely.'

Unconditional positive regard

The 'warm acceptance of each aspect of the client's experience' (Rogers, 1959, p. 209; see Chapter 12) is communicated to the client to facilitate the development of his or her unconditional positive self-regard. Charlotte sometimes chose not to share her decisions with her children because, 'Well, the consequence will be the same attitude probably that I've had from them before … they will be judgemental.' Person-centred therapy can be a means for older adults to free themselves from the constraint of being judged and classified into ageism stereotypes, so that they can live more self-directed lives.

By clearly and warmly communicating unconditional positive regard, the person-centred therapist is facilitating what is perhaps a naturally unfolding process for many older adults. Several of the transformative changes of gerotranscendence (Tornstam, 2005) exemplify emancipation from conditions of worth. For example, with an *emancipated innocence* comes a new capacity to transcend needless social conventions; and, somewhat paradoxically, with a *decrease of self-centredness*, or removal of self from the centre of one's universe, evolves a level of self-confidence that feels appropriate.

Some of the post-classical person-centred therapies, for example clarification-

oriented psychotherapy (Sachse, 2004), which do not regard unconditional positive regard as sufficient for therapeutic change, might be more appropriate for older clients, particularly those like Charlotte who evidence some cognitive impairment. The intent of these approaches is to direct, guide and encourage clients toward particular experiences that are deemed therapeutic by the therapist (see Chapter 12). Reminiscence, life review and guided autobiography are examples of well-researched, directive approaches that could be readily incorporated into person-centred therapy sessions.

Charlotte mentioned, 'I feel lonely. None of my neighbors is my age or is interested in what I care about.' In therapy, older adults often express a conflict between the need to be involved with peers or former colleagues and the feeling of being entitled to rest after a long life of responsibilities. Person-centred therapy can assist them to experience a life review, in their present, and link it to future activities – that is, to help these clients bring their past to the forefront, as a *present* that is still alive in their inner self. An illustration of this would be to evidence empathy during reminiscence or life review without necessarily using the past tense.

Congruence

According to the 'three process' model of congruence, if 'what is being experienced at gut level, what is present in awareness, and what is expressed to the client' (Rogers, 1980, p. 116; see Chapter 13) align, the therapist will evidence what is '"functionally one condition" (Bozarth, 1998, p. 80), "one fundamental way of being, relating and acting", or the "encounter condition" (Schmid, 2001, pp. 220–1)' (see p. 196). This fluid process of appreciating and extending oneself in an encounter with another is akin to what one of the authors (AW) calls *witnessing*: sitting with the severely depressed nursing home resident who repeatedly proclaims that she wants to die, or walking alongside the agitated dementia patient – a Holocaust survivor with a blurred blue number tattooed on her forearm – as she paces the halls of the nursing unit.

Charlotte told the therapist: 'Imagine, if you woke up one morning and did not immediately recognize your bedroom. I saw everything blurred and I could not remember where I was for a while. I felt frightened.' Anxiety, feeling threatened and confusion do emerge whenever incongruence is experienced (Rogers, 1959). These can block the individual from progressing and may linger in the atmosphere of the session.

Being with a client with disruptive memory and possible behaviour problems (for example, repetitive discourse or irritability) can challenge our own congruence. We must guard that feelings of antipathy at worst, or a lack of identification at best, do not affect our interactions with a client who is struggling. As therapists, we should be able to attune with the client so that he can feel congruence between the real and the ideal selves and improved psychological adjustment, as we remain convinced that we have the ability to generate a non-judgemental space of reassurance.

Congruence in encounters such as these requires the therapist to be attuned to the experiences and meanings which are most poignant to the client (see Chapter 13) or, in some cases, which he or she supposes they might be (as with a dementia patient). Similarly, with the *presence* conceptualization of congruence, the therapist brings the intuitive and the transcendent to an encounter, for example with an elder confronting an existential crisis, moving from 'knowing and sensing below the level of consciousness, to a conscious awareness of the organism and the external world, to the transcendent awareness of the harmony and unity of the cosmic system, including humankind' (Rogers, 1980, p. 133; see also Chapter 13). This conceptualization of congruence is reminiscent of gerotranscendence; the cosmic dimension, through the dimensions of the self and of social and personal relationships, could be brought to the encounter with the client who is also seeking to grow and to transcend his or her current state or self.

Conclusion

Among the principles for working with older adults that Pörtner (2008) outlines are those applicable to interpersonal relationships in general, for example 'Individual experience is the key to understanding' (p. 23). Others are particularly crucial in working with frail elders, including those with dementia. 'Clarity [in communication] provides safety and trust' (p. 21) reminds the younger therapist that what is clear to him or her may not be clear to older clients, who may be confused or forgetful or whose life experience leads them to different associations about what is communicated to them. 'Self-responsibility is existential' (p. 27) challenges us to help older adults maintain their autonomy to the greatest extent possible and, when physical or cognitive decline severely limit their capabilities, to find new, creative ways to enable them to be functioning, acting persons.

Contrasting views on ageing are cast as a compression of morbidity versus decrement with compensation, or as successful ageing versus conscious ageing, a position that challenges us to examine the shadow parts of our future selves (Moody, 2009). Regardless of the therapist's and client's perspectives on the human life course, a person-centred approach is appropriate as personal growth and development are, as we have seen, desired outcomes for older adults, including those with significant age-related decline. Losses in later life may be profound, but many older adults cope well and thrive, sustaining personal meaning with wisdom and creativity.

This chapter reviewed the life course perspective that is central to current ageing theory and outlined the developmental stages of later life; it challenged therapists planning to work with older clients to identify and confront their own biases about older adults; and it examined specific ways to apply the core concepts of person-centred therapy with older clients, including those with mild cognitive impairment, like Charlotte, and dementia. We have seen that the three intertwined conditions – genuine empathic acceptance (see Chapter 11) – and praxis

traditions of person-centred therapy are particularly suited to older adults, whose personhood is sometimes unacknowledged by others but whose losses are balanced by gains and growth.

Points for reflection

- What biases about older adults do your friends and colleagues, as well as the general culture, seem to hold? Which do you share, and how might they affect your therapeutic practice with older clients?
- In what ways might a person-centred perspective and practice help you to understand some of the challenges that older adults experience? How might you then bring this new understanding into your therapeutic work, focusing on older clients' psychological growth?
- Using person-centred principles and practice, how might you help older adults with cognitive impairment regain their sense of control and accomplishment?
- As therapists, how can we facilitate older adults' personhood in ways that preserve and enhance their ability to dream about and plan for their future?
- In what ways can you incorporate older clients' bodily and facial expressions of emotions, with or without verbal communication, into your practice of the empathic method?

Key readings

- American Psychological Association (2004). Guidelines for psychological practice with older adults. *American Psychologist*, 59(4), 236–60.

These consensus guidelines provide clinicians with a frame of reference for their work with older adults, as well as basic information and references in the areas of attitudes to bring to their clinical practice, general aspects of ageing, common clinical issues, assessment, intervention, consultation, and continuing education and training.

- Kitwood, T. (1997). On being a person. In *Dementia reconsidered: The person comes first* (pp. 7–19). Buckingham: Open University Press.

This chapter presents a new person-centred care model, designed specifically for dementia care and based on Rogers' person-centred therapy.

- Moody, H. (2009). From successful aging to conscious aging. In J. Sokolovsky (Ed.), *The cultural context of aging: Worldwide perspectives* (3rd ed.). Westport, CT: Praeger Publishers.

Prominent gerontologist Harry Moody contrasts his conscious ageing perspective, which incorporates the notion of decrement with compensation, with the dominant

successful ageing paradigm (see also the quotation earlier in the chapter), which he contends may help to perpetuate ageist views and policies.

■ Pörtner, M. (2008). *Being old is different: Person-centred care for old people*. Ross-on-Wye: PCCS Books.

Marlis Pörtner, herself an 'old person', liberally uses vignettes to explain how basic person-centred principles can be implemented by professional and volunteer caregivers to improve the life quality of older adults.

■ Tornstam, L. (2005). *Gerotranscendence: A developmental theory of positive aging*. New York: Springer.

Swedish gerontologist Lars Tornstam presents his theory of growth and development in older adults with supporting research, including in-depth interviews with individuals who have experienced qualitative shifts in how they perceive and engage some of the major issues and dilemmas of later life.

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21

A person-centred approach to grief counselling

DALE G. LARSON

This chapter discusses:

- Contemporary theories of grief and mourning and their implications for counselling
- The person-centred approach and grief counselling
- Person-centred experiential grief counselling interventions
- Evidence for the efficacy of a person-centred approach to grief counselling

Loss, and with it the mental and physical pain so familiar to bereaved persons, is an inescapable part of life. Despite its often overwhelming intensity, grief is now understood to be a natural condition – the human reaction to loss – and for most people is expected to abate over time and frequently lead to psychological growth. Given this understanding, the role of grief counselling is to accelerate or unblock the natural healing process, particularly if this process is moving more slowly than expected, or if the reaction to a loss is severe or protracted.

Our understanding of grief and the needs of grieving persons has advanced significantly in recent years, but these insights are typically not connected to specific counselling theory and practices that could then provide a foundation for effective grief counselling. In this chapter, I present a rationale for a person-centred approach to grief counselling serving as this foundation. I connect this approach with contemporary theories of grief and mourning and the needs of bereaved persons, and then illustrate the approach in action and review relevant research.

Theories of grief and mourning

Defining grief is difficult because of the myriad forms it takes. Although often thought of as only a distressed emotional reaction, grief is a much more all-encompassing experience, affecting the bereaved person's cognitive, behavioural and physiological status (Stroebe, Hansson, Schut, & Stroebe, 2008a). The grief response also varies tremendously, depending on an array of factors such as the circumstances of the death and the bereaved person's gender, attachment style and relationship with the deceased. Mourning – the integration and expression or public display of grief over time – is also quite varied and is significantly shaped by society, culture and religion.

Dual-process and task-based models

Despite the complex and idiosyncratic nature of grief and mourning, thanatologists have succeeded in identifying definite patterns and relations in them. Two of the most comprehensive and influential grief theories are the dual-process model of Stroebe and Schut (1999, 2010) and the task-based model developed by Worden (2009).

The dual-process model views bereavement as defined by two orientations: loss and restoration. Both orientations are present in the coping responses of each bereaved individual. In the loss orientation, the griever confronts and processes the loss experience – doing the *grief work* of yearning, going over memories, feeling the pain and finality of separation, crying over the loss, and having emotions ranging from despair to relief while coming to terms with the loss. As Stroebe et al. (2007) say, 'Healthy grief work involves … facing up to the reality of the loss' (p. 470). In the restoration orientation, the griever focuses on adjusting to the secondary stressors that come after the loss – dealing with all the changes the loss brings, finding distraction (and rest) from grief, and exploring areas of new growth.

As the griever struggles to come to terms with the loss, oscillation between these two orientations occurs. This oscillation serves an adaptive regulatory function that works best when movement between the two orientations is balanced and flexible (Hansson & Stroebe, 2007). When balanced oscillation breaks down and the griever becomes stuck in either the loss orientation (extreme rumination) or the restoration orientation (extreme denial and avoidance), complicated grief can develop. From the perspective of the dual-process model, grief counselling will be most effective if it helps the griever oscillate between loss-oriented and restoration-oriented experiences in a balanced and flexible fashion, without becoming stuck in either.

Worden's task-based model sees mourning as an active process entailing the completion of four tasks: (1) accepting the reality of the loss; (2) processing the pain of grief; (3) adjusting to a world without the deceased; and (4) finding an enduring connection with the deceased in the midst of embarking on a new life. The third task of adjusting to a world without the deceased is quite similar to the restoration orientation of the dual-process model (Worden, 2009), with some qualifications (Stroebe et al., 2007), and the other three tasks overlap with the loss orientation. The four

tasks serve as markers for the natural healing process of grief and as keys to understanding when grief is not working. In the task based-model, complicated mourning reactions occur when one or more tasks are impeded, resulting in what Worden terms 'abnormal grief reactions' (for example, chronic, delayed or exaggerated grief reactions). To succeed, grief counselling must help clients to complete these tasks.

Meaning-making

Both the dual-process and task-based models include a prominent role for meaning-making and meaning reconstruction in the adaptation to loss (Gillies & Neimeyer, 2006). Major losses require grievers to re-evaluate and reconstruct their schemata for self, others and the world as they search for the meaning of the loss and the meaning of life without the deceased. Traumatic loss presents additional challenges to the bereaved (see Chapter 24) as it can shatter basic assumptions about life and require grievers to create a more viable assumptive world that is both credible and tolerable (Janoff-Bulman, 1992). Efficacious grief counselling assists clients in these meaning-making processes.

Continuing bonds

An emergent view in the bereavement field is that continuing bonds (Field, 2008) with the deceased are an important component of healthy adaptation to loss. Although ongoing research is examining when continuing bonds are helpful and when they are not, the dominant view is that counselling is likely to be more effective when it helps clients to remain connected to the deceased in ways that do not interfere with moving adaptively into the future.

A natural and potentially growthful process

Grief is now viewed as a natural, self-limiting, healing process (Corr, Nabe, & Corr, 2006). When this process goes awry, complicated grief and grief-related major depression can develop. Clinicians need to recognize these conditions and find a balance between normalizing extreme reactions to loss and possibly not providing enough care, and reducing the pain of grief and possibly interfering with a natural adaptation to loss (Zisook & Shear, 2009). In this view of grief as a natural healing process, painful emotions of sadness, anger, guilt, shame and anxiety are seen as potentially motivating and guiding psychological adjustment.

This adaptive role for emotions might seem foreign to some therapists but certainly not to person-centred counsellors, who see therapy as aiding clients in gaining awareness of their inner reactions so that the 'organismic valuing process' (Rogers, 1959) may guide growth and lead to health-promoting choices. The idea that grief often brings growth and gain, along with the pain, is also now widely accepted (Hogan & Schmidt, 2002). Given these views of grief, the role of counselling is essentially to help clients by getting grief working for them.

The person-centred approach and grief counselling

Many authors note the fit between a person-centred counselling approach and the needs of grieving clients, citing:

- a focus on the uniqueness of the human experience (Haugh, 2012);
- an emphasis on the actualizing tendency (Haugh, 2012; Servaty-Seib, 2004);
- an encouragement and facilitation of contact with emotions and experiencing (Barbato & Irwin, 1992);
- an approach that follows the client's agenda and facilitates an individual, diverse process (McLaren, 1998);
- a non-directive style that promotes self-reliance and a mastery of bereavement tasks (Goodman, Morgan, Juriga, & Brown, 2004).

The fit is further demonstrated by a more detailed look at the needs of grieving clients and the therapeutic conditions provided by the person-centred counsellor.

Need for a supportive and empathic relationship

It is the relationship that heals. This therapy axiom is surely true in grief counselling, where the client's need for a safe, supportive and empathic relationship with a reliable caregiver is magnified by ruptured attachments and disrupted social support systems. Bereaved clients often feel painfully alone in their experience of loss, for a multiplicity of reasons:

- They are often grieving for the very person who would normally be their main source of support in times of stress.
- Their natural support system soon exhausts itself, and supportive contacts with caring family and friends diminish in frequency as the rest of the world charges ahead.
- Their disclosure of grief-related distress is discouraged by a society averse to death-related content, especially when the losses are stigmatized (for example, as the survivor of a suicide or AIDS death).
- They have suffered a traumatic loss (for example, the loss of a child or a homicide) and the need for a supportive relationship – a secure base – is even greater as they must adapt to a world that no longer feels safe.

Jordan and Neimeyer (2003) echo these themes when they say that the 'common and probably most important factor in all bereavement interventions' is 'the encounter with compassionate and empathically-attuned caregivers who provide mourners with a healing experience of being understood and supported in their journey of loss' (p. 780). The person-centred counselling approach, with its emphasis on a deeply empathic and caring therapeutic relationship, precisely fulfils this fundamental criterion for effective grief counselling. The match between a person-centred counselling approach and the needs of bereaved persons is further

highlighted when the core conditions of congruence or authenticity, unconditional positive regard and empathic understanding are each examined in relation to the grief experience:

- *Congruence or authenticity:* Grievers need an authentic companion as they grapple with existential issues that touch core dimensions of the human condition.
- *Unconditional positive regard:* Grievers need to be accepted, and to accept themselves, as they struggle with feelings of shame and guilt, worry and regrets, and with a widening gap between their inner experience and others' expectations (for example, 'Isn't it time to move on?' or 'You are young and can have another child'). This acceptance is invaluable as grievers work to discover their inner timetable for grief and their way through the pain of loss. To do this, they require a non-judgemental listener who is unafraid to be witness and be present with the intense and often unsettling emotions and thoughts that grief brings. The griever's everyday support system can rapidly exhaust itself and is also not capable of providing a consistent 'holding environment' for these strong reactions to loss.
- *Empathic understanding:* Deeply experienced and communicated empathic understanding is the hallmark of the person-centred approach. The empathically attuned counsellor forms successively more accurate constructions of the client's experience, and as clients more fully 'experience their experience', they find that they can:
  - develop an understanding of self that is more congruent with their actual lived experience (Rogers, 1961);
  - accept and make sense of their loss experiences;
  - have the emotions of grief guide their adjustment to loss;
  - clarify, accept and integrate new experiences of self;
  - discover new meanings in the painful events, and discover and explore emerging directions for growth;
  - establish continuing bonds with their lost loved ones that are not maintained through the pain of loss.

The encounter between the deeply empathic person-centred grief counsellor and the distressed griever does, however, entail risks for both client and counsellor. Grief counsellors can experience secondary or vicarious traumatization (Figley, 1995; Larson, 2000) as a consequence of their emotional involvement with highly distressed clients, and this can adversely affect both the counselling process and the counsellor. The grief counsellor, like the grieving client, must find a way to achieve a balanced stance towards intense emotional experience. For counsellors, this balance is lost when they identify with, rather than empathize with, their clients' experiences. When empathy loses its 'as if' quality, counsellors find themselves in what I have called the 'helper's pit' (Larson, 1993), and balanced empathy gives way to counsellor self-focus, personal distress and an increased likelihood of burn-out.

One of the best ways to prevent counsellor burn-out is to be effective in our counselling efforts. I have found that, in addition to a more classic way of working

with bereaved persons, there are some practices from the wider circle of more experiential and integrative practices that can be helpful too. Some of the interventions that I have found helpful include:

- having a photo of the deceased displayed during each counselling session;
- sharing books and readings that offer psychoeducational input;
- meeting with other family members at least once to gather an understanding of the family system's response to the loss;
- referring clients to local bereavement support groups as a supplement to our work together;
- listening for and supporting the establishment of new goals that restore meaning to life;
- using the empty-chair technique to facilitate different facets of coming to terms with the loss.

Several of these practices are illustrated in the case study of Bruce presented below. Although the empty-chair dialogue and other of these interventions can entail more counsellor directiveness than is usual in person-centred work, these interventions are entirely non-directive concerning the client's content, and they retain the quintessential inner-directed quality of person-centred counselling.

Another specific intervention that I find can be enormously facilitative in grief counselling is the 'first-person response' (Cain, 2010; Larson, 1993). Here, the counsellor speaks from the client's point of view using the first-person voice. This mode of communicating can be particularly helpful in grief counselling because grievers so often search for answers to profound existential questions, what I term *grief's questions* (Larson, 1993; see Box 21.1). There are no easy answers to grief's questions; however, by hearing and reflecting them, no matter what style of response is used, the counsellor can help grievers live the questioning process and discover their own answers. Examples of the first-person response with a bereaved client can be found in Rogers's (CRR) demonstration interview (Milton H. Erickson Foundation, 1985) with Peter Anne (PA), who had miscarried twins 2 years previously and was possibly pregnant at the time of the interview:

PA: … I guess I question myself in a lot of ways too. If I had made attempts earlier, would it have been easier?

CRR: Uh-huh, uh-huh. 'Should I have laid aside my career a little earlier and tried to become pregnant?'

PA: Yeah, because … I would have had two little kids two and a half years old.

CRR: And so you're asking, 'Did I make a mistake?'

PA: Yeah. And that's … a scary thought, to think that your whole life has been a mistake along the way.

CRR: Uh-huh, uh-huh. 'Did I make a very grave error in not having made the attempt sooner?' …

Box 21.1

Grief's questions

- *Why me? Why did this have to happen?* These are probably the first questions nearly every bereaved person asks.
- *What's happening to me?* The grieving person feels so different and wants to know what is happening.
- *How can I go on?* Feelings of hopelessness are common.
- *What can I do?* Although the 'problem' of grief has no easy solutions, a cascade of advice inevitably pours in from others, and there is often a painful discrepancy between these expectations and the griever's inner experience.
- *Who will help me?* There are often many surprises – some pleasant, some unpleasant – as the grieving person seeks out support from family and friends.
- *What do I need?* A fog of ambiguity can envelop the griever, making it difficult to know what would be most helpful for him or her.
- *Will this ever end?* The griever asks, 'How long will this last?', 'When will I feel better?'
- *Who am I now?* Changes in personal identity lie at the core of the mourning process.
- *How will my life be?* The final task of grief is to become an active agent for one's own wellbeing and to reinvest in life.

Person-centred grief counselling in action

Bruce

Bruce is a 40-year old Caucasian Silicon Valley engineer I met with for 40 sessions over a period of 2 years. Bruce's son Adam, aged 7, had died suddenly from a cerebral haemorrhage. Bruce was in deep despair at the outset of counselling. A dedicated father, he was confronting the unimaginable: the loss of his beloved son. His grief and grieving process were intense and prolonged and had a traumatic component, which I find typical for the bereaved parents of young children.

At the outset of counselling, Bruce often had extreme emotions of anguish and yearning. The intensity and frequency of the reactions gradually diminished over the course of therapy, but these 'grief attacks', as we called them, were moments when Bruce confronted and lived through the trauma of the loss as he struggled to accept this reality and integrate it into his world and experience of self.

Bruce consistently used evocative metaphors to describe his grief: he was on a 'long, painful road' with broken glass cutting his bare feet; his remaining family was 'wobbly', like a 'table with three legs' (himself, his wife and their other son); the loss was an 'earthquake', followed by aftershocks; he was a 'man with one arm'. Bruce was able to reach deeper levels of feeling and meaning by attending to the 'bodily felt sense'

(Gendlin, 1996) that he had for each of these experiences, and the richness and depth of the insights that came to him were remarkable. My overall response style in the therapy was classically person-centred: few questions, almost no advice, and the majority of my responses focused on the feelings and meanings Bruce communicated.

Each week Bruce brought a photo of Adam to our sessions, and he had extensive imaginal conversations with Adam through empty-chair work. In these conversations, Bruce often repeated: 'I have not forgotten you, Adam. My love has not diminished.' Extensively refined and researched within the ever-expanding person-centred tradition (Elliott, Watson, Goldman, & Greenberg, 2004), this powerful experiential intervention is now used in grief counselling by therapists from many theoretical persuasions, including cognitive grief therapy (Malkinson, 2007, p. 157 – the 'as if' strategy), and cognitive-behavioural therapy for complicated grief (Shear, Frank, Houck, & Reynolds, 2005). The empty-chair dialogue facilitates processing the loss, developing a healthy continuing bond with the deceased and adjusting to a life without the loved one.

I will never forget the day Bruce so eloquently and poignantly conveyed the suffering he confronted. He told me he had always tucked both his sons into bed at night, and told them stories. When he had a scary dream about his children, he would go into their bedroom to check on them. Now his only solace was when Adam appeared to him in a dream. He said, 'I wake to my nightmare.'

When Bruce asked me questions about grief and the grief process, I answered to the best of my ability. An engineer, he wanted to know how things worked, and he found that the task-based and dual-process models made sense to him. He would then often point to the *zigzag* nature of his grief journey, with profound moments of loss and yearning followed by 'vacations from grief' in which he began to find pleasure again. Near the end of our work together, he described himself as coming back into his life and observing what had happened while he had been gone 'on a vacation in hell'.

Bruce's grief process illustrates what both the dual-process and task-based models emphasize: that adaptation to loss involves more than *grief work*. There is also the work of adjustment and restoration – adjusting to a world without the loved one, setting new goals in life and generally reinvesting in life. These restoration and adjustment processes of the task-based and dual-process models can include an element of avoidance or denial, of consciously or unconsciously diverting one's attention from the loss experience itself. The dual-process model says that when grief is working, the griever flexibly oscillates in a balanced fashion between loss and restoration orientations, and does not get stuck at the extremes of either – neither excessive rumination nor rigid denial or repression.

In addition, when grief is working, the adjustment and restoration-oriented processes that are an important part of bereavement coping are activated as grief-related emotions are fully experienced and worked through. Person-centred experiential theorists say that 'every feeling has a need, and every need has a direction for action' (Elliott et al., 2004, p. 24). This axiom is confirmed in grief counselling when clients

have sudden realizations like 'I don't need to make the trip this year to the lake where we scattered our son's ashes' or 'Now that Plan A is not going to happen, I need to make Plan B work for me.' One day, after processing cherished memories of his son on the sports playing field, Bruce resolved to set up a scholarship for other boys in his son's name. This idea for creating meaning through a legacy for Adam was a 'direction for action' emerging directly from Bruce's deep experience of loss.

Insights into this pattern of deeply felt emotion leading to adaptive real-world actions can be found in the work of Pascual-Leone and Greenberg (2007), who studied 'moment-by-moment steps in emotional processing' in therapy with clients in experiential therapy for depression and interpersonal problems. They identified patterns of productive emotional processing and showed how painful and unpleasant emotions can promote healing when they 'propel the client on a healthy self-organizing trajectory that reaches its completion as a meaningful, emotionally differentiated, and integrative experience' (2007, p. 886). This therapeutic endpoint is perhaps similar to the adaptive grief outcome Zisook and Shear (2009, p. 68) term 'integrative' or 'abiding' grief. These detailed explorations of how feeling and meaning unfold in effective therapy can help to unravel the paradox that the pain of loss actually helps to process the loss: that to change grief, you must experience grief.

Facing up to the reality of losing one's child is probably the most difficult of all human experiences, and Bruce's courage in doing so gave me the courage to be his companion on that journey. When the counselling ended, Bruce said that he had at last arrived at a different place, a place where he could hold Adam in his heart without the intense anguish of loss, but with the cherished memories of the son he would always love dearly and never forget.

Empirical evidence

Does grief counselling work?

Although the efficacy of person-centred counselling with bereaved clients has received little direct empirical attention, a review of grief counselling and psychotherapy research in general does provide important perspectives for consideration here, particularly in light of recent controversies in the field.

In the past decade, a pessimistic view of grief counselling has emerged, with claims that it is ineffective or possibly harmful with normally bereaved clients. Critical evaluation of these claims (Hoyt & Larson, 2008, 2010; Larson & Hoyt, 2007a, 2007b, 2009) has led my colleague, William Hoyt, and myself to conclude, first, that there is no empirical or statistical basis for the existence of iatrogenic effects for grief counselling, a conclusion confirmed by other authors (Stroebe et al., 2008b; Worden, 2009). Second, we believe that the generally pessimistic portrait of grief counselling outcomes that pervades the literature has resulted from a lack of ecological validity of the modal research design (that is, interventions and samples are not similar to the real-world treatments and clients) and from misinterpretations of extant meta-

analytic findings. When these issues are corrected for, a relatively optimistic picture is revealed. A major implication of the new perspective is that bereavement professionals can enjoy a more realistic and positive view of their helping efforts.

Encouraging results can also be found in research testing the efficacy of person-centred therapy (see Chapter 31 for a thorough review of research on the person-centred approach). In a large-scale study comparing the cognitive-behavioural (n = 1045), person-centred (n = 1709) and psychodynamic (n = 261) approaches, Stiles, Barkham, Mellor-Clark and Connell (2008) found that all three approaches averaged a dramatic improvement (overall pre-to-post effect size = 1.39) and that the different therapeutic approaches had essentially equivalent outcomes. Significantly, bereavement was one of the 14 presenting problems treated.

In addition, the psychotherapy outcome research literature consistently shows that *common factors* (for example, the counselling relationship and working alliance, and the person-centred core conditions of empathy, respect and genuineness) appear to be more influential in determining therapy outcomes than are specific factors like therapeutic techniques or models (Wampold, 2001, 2010). In fact, empathy alone has been shown to account for more variance in outcomes than treatments or techniques (Bohart, Elliott, Greenberg, & Watson, 2002; Wampold, 2001). Given these findings, a compelling case can be made for a person-centred approach as the foundation for grief counselling in view of its focus on the therapeutic relationship, its provision of common factors and its fit with the needs of grieving clients.

Who needs grief counselling?

Grief counselling, like other therapeutic interventions, tends to be effective for those who seek it out. At this point, probably the best answer to the question 'Who should receive grief counselling?' is provided by Gamino and his colleagues (Gamino, Sewell, Hogan, & Mason, 2009–2010). Reviewing the research, they conclude that grief counselling is appropriate for all those bereaved persons who answer yes to the following two questions: 'Are you having trouble dealing with the death?' and 'Are you interested in seeing a grief counsellor to help with that?'

Conclusion

The person-centred approach provides an excellent foundation for grief counselling. The phenomenological and experiential focus of the person-centred approach and the deeply empathic counselling relationship it promotes match the needs of bereaved clients and allow for flexible responses to their often idiosyncratic reactions. Empathic understanding, exploring, exposure and, most principally, experiencing are at the heart of effective grief counselling and healthy grieving. These elements, brought to life in an authentic and caring helping relationship, with a counsellor who believes in the client's healing capacities, define the person-centred approach to grief counselling.

Points for reflection

- Is person-centred grief counselling different from classic client-centred therapy? If so, what are the differences?
- How is the healing process of grief the same as or different from the change process in therapy with other client issues?
- How well might this approach to counselling work with other losses, such as divorce, illness or failure?

Key readings

- Becker, E. (1973). *The denial of death*. New York: Free Press.

This classic work offers insights into the psychology of death, dying and loss that can inform all our efforts to counsel bereaved and dying persons and all others.

- Haugh, S. A person-centred approach to loss and bereavement. In J. Tolan & P. Wilkins (Eds.), *Client issues in counselling and psychotherapy: Person-centred practice* (pp. 15–29). Thousand Oaks, CA: Sage Publications.

This chapter is devoted to an exploration of the person-centred approach in the context of loss and bereavement.

- Larson, D. G. (1993). *The helper's journey: Working with people facing grief, loss, and life-threatening illness*. Champaign, IL: Research Press.

This book focuses on the self-care, relationship and therapeutic communication skills essential for success in counselling people facing grief, loss and life-threatening illness.

- Stroebe, M. S., Hansson, R. O., Schut, H., & Stroebe, W. (Eds.). (2008). *Handbook of bereavement research and practice: Advances in theory and intervention*. Washington, DC: American Psychological Association.

Stroebe et al.'s text is the most comprehensive and authoritative review of research, theory and practice in the area of bereavement.

- Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death*. San Francisco, CA: Jossey-Bass.

This book is an insightful treatise on the difficulty of facing death and loss, with practical advice for counsellors.

- www.scu.edu/hospice

This is Dale Larson's homepage, with a range of resources for working with bereaved clients.

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22

Clients with contact-impaired functioning: Pre-Therapy

DION VAN WERDE AND GARRY PROUTY

This chapter discusses:

- 'Contact-impaired functioning' as a person-centred understanding of certain forms of human suffering
- The 'pre-expressive self', a concept derived from the personal experience of the second author, case histories and quantitative explorations of Pre-Therapy
- Pre-Therapy: a person-centred method for working with contact-impaired functioning, and for dealing with it in a psychotherapeutic way

Contact-impaired functioning and the 'pre-expressive self'

The second author's concern with the concept of contact originates from his life history, coming as he did from a family background where different family members experienced different forms of contact-impaired functioning due to learning difficulties and/or psychosis (Prouty, Van Werde, & Pörtner, 2002, pp. 3–4). It was only later, when he was studying and being supervised in his clinical practice by Eugene Gendlin, that 'Pre-Therapy' as such was born, at the crossroads of personal and professional experience. Seen in the framework of person-centred therapy, it represents an evolution in person-centred and experiential theory and practice (Prouty, 1994). Carl Rogers, listening to Garry Prouty's lecture at the celebration of the 15th anniversary of the Chicago Counselling Center in 1986, explicitly acknowledged his innovative and historically important professional work (Prouty et al., 2002, pp. 8–9).

Prouty had long recognized the influence of his 'schizophrenic' brother with

learning difficulties on the development of Pre-Therapy. He says (see the previous edition of this book):

> One day when I was eleven or twelve years old, I invited a friend to visit my home. While we were talking I said 'I wonder if he (brother) understands what we are saying?' To my intense surprise my brother responded by saying 'You know I do Garry', and then he relapsed back into his autistic-regressed state. This 'episode of lucidity' 'haunted' me for many years, often giving the feeling 'there was someone in there' (later to be understood as the pre-expressive self). It was several weeks *after* the publication of my first book (Prouty, 1994) that the meaning of that experience became clear. In the foreword of the 1994 book, Luc Roelens, a Belgian psychiatrist, reported a similar case arguing against the medical understanding of psychotic states. He describes several cases of patients suddenly making contact. One case involves a woman with a severe, chronic and muted catatonia. When informed her husband had fallen off the roof of their home and broken his leg, she promptly replied by saying she would go home and take care of everything. There was no relapse. A four and ten year follow-up revealed only a mild autism. Another 'episode of lucidity' involved a mute male 'schizophrenic' who had been in a dementia like state. He was drinking by a nurse through a straw when he coughed and spat all over her. He immediately responded by saying: 'Excuse me, I did not mean to do that'. After that he relapsed into his isolation.
>
> My brother and these cases express 'episodes of lucidity' which indicate the presence of the 'pre-expressive self' embedded in autism, regression, psychosis, brain-damage, [learning difficulties] and dementia and so on (Dodds et al., 2004). The 'episodes of lucidity' manifest the pre-expressive self.

The pre-expressive self is also revealed in other signs. First, is the fact that all case histories and quantitative studies illustrate movement from fragmented, incomplete, bizarre, incoherent expression to fuller cogency and self-congruence – a movement from a pre-expressive state to an expressive state. Signs of the pre-expressive self are also observed in the verbal process of psychotic expression. The semiotic structure of initial psychotic expression can be characterized in the following way. These pre-expressive forms have no general context to derive meaning from, and they have no referent to complete their symbolic function. This means that the expression lacks reality sense and appears to be void of a reality source. Hence the dismissal of these forms by psychiatry.

For example, a young male catatonic expresses himself by repeatedly saying 'Priests are devils.' By carefully using 'word-for-word' reflections, this eventually processed into the reality of a homosexual overture by a local priest. The highly condensed metaphor contained 'latent-reality' content. The movement from a highly condensed metaphor to latent reality is called a 'pre-expressive process'. Without understanding that latent reality is 'packaged' in a pre-expressive way, the therapeutic potential of psychotic expression is not envisioned.

Pre-Therapy

The theory of Pre-Therapy evolved directly from Rogers' (1957, p. 96) concept of psychological contact. As he described, 'all that is intended by this first condition is to specify that the two people to some degree are in contact; that each makes some perceived difference in the experiential field of the other'. Prouty (1990) asserts that such a definition lacks theoretical conceptualization leading to treatment or quantitative developments. Pre-Therapy is a theory of psychological contact specifically designed to provide concepts of treatment and measurement. Rogers goes on to say (1957, p. 96), 'this first condition of therapeutic change is such a simple one that perhaps it should be labelled an assumption or a *precondition*'. Prouty (1976, 1990) thus coined the term 'Pre-Therapy'. Pre-Therapy as psychological contact is a precondition for client-centred therapy as applied to, for example, persons who have 'schizophrenia' or have learning difficulties, and those with dementias.

Psychological contact

Sanders and Wyatt (2002) present a history of contact within client-centred theory. Gestalt and psychoanalytic psychotherapies (Havens, 1986; Perls, 1969; Perls, Hefferline, & Goodman, 1969) also present views of contact. Contact theory as presented in the work of Garry Prouty is structurally described as (1) contact reflections, (2) contact functions, and (3) contact behaviours (Prouty, 2003). *Contact reflections facilitate the contact functions, resulting in the emergence of contact behaviours.*

- *Contact reflections* are extraordinarily concrete and literal. They include situational, facial, word-for-word, bodily and reiterative therapist reflections. They are the therapist's 'work'.
- *Contact functions* are an expansion of Perls' (1969) concept of contact as an 'ego function'. They are reality, affective and communicative functions.
- *Contact behaviours* are the emergent social words and sentences of the client. These become the basis for measurement.

Contact functions

Merleau-Ponty describes human consciousness in terms of three polarities: the 'world', the 'self' and the 'other' (Merleau-Ponty, 1962, p. 60). Prouty et al. (2002, pp. 12–13) state, 'I live with and consciously experience the world in all its immanent power. I live with and experience the self with all its psychological value. I live with others and all their significance.' These are the *structural priorities of involvement* for our daily conscious life.

Such a description can be translated into psychological terms by translating Perls' (1969, p. 139) concept of contact as an 'ego function' into three awareness function(s): reality (the world), affect (the self) and communication (the other). One is aware of, connected with, the outer, inner and social world.

Reality contact

Reality contact (the world) is defined as the awareness of people, places, things and events. If we describe the world as we concretely experience it, we can see that we live with all types of things – door handles, shoes and so on. Our world is 'peopled'. They are on planes, on buses, in houses, practically everywhere. Spatial loci or 'places' are a concrete part of our reality. We live in space. Things are in space: 'The ball is here, you are there.' Things, people and places have their temporal locus in events: 'I am here now, you are there now.' This tapestry of things, people and temporal-spatiality is the weave of our conscious reality.

Affective contact

Affective contact is the client's response to the world and the 'other'. It is defined as the awareness of moods, feelings and emotions – each phenomenologically distinct. Mood is subtle and diffuse. It is a background sensing or a 'colouring' of current experience. I can be with friends yet experience an anxiety or depression without realistic focus. Feeling is clearer in that it has a more specific locus; it is a response to the event itself, as in 'I liked your smile' or 'The cat makes me angry'. Instead of being background, it is foreground. Emotion is affect that is much more intense. It is sharp, clear and more filling of psychological space. It has the quality of being totally foreground: 'I am enraged if you slap my wife.'

Communicative contact

Communicative contact is defined as the symbolization of reality (the world) and affect (the self) to others. It is the meaningful expression of the client's perceived world and self. It reveals itself generally through social signs such as words and sentences.

The development or restoration of the contact functions (reality, affect and communication) is the necessary precondition of psychotherapy and functions as the theoretical goals of Pre-Therapy (Prouty, 2002; see also Peters, 2008, for a developmental view).

Contact behaviours

Contact behaviours are the emergent behavioural changes that arise from the application of Pre-Therapy. They are the operationalized aspect of psychological contact.

Reality contact is operationalized as the verbalization of people, places, things and events. Affective contact is operationalized as the bodily or facial expression of affect as well as the use of feeling words (for example, 'sad' or 'happy'). Communicative contact is operationalized as the use of social words and sentences.

These dimensions of contact can be measured, and such measurement reflects a shift in the client from a pre-expressive to an expressive state. We measure the client's contactful expression about the world, self and the other (Box 22.1).

Box 22.1

Evaluating the effect of Pre-Therapy on contact behaviours

The Pre-Therapy Rating Scale (PTRS; Prouty, 1994) and the Evaluation Criterion for the Pre-Therapy Interview (ECPI; Dinacci, 2000) are the most frequently used instruments for assessment of contact behaviour. Psychometric and content analyses indicate that these measures focus mainly on communicative contact (Dekeyser, Prouty, & Elliott, 2008).

- *Descriptive process-outcome evaluations* assess whether the contact behaviour of Pre-Therapy clients improves over time.

Dinacci (1997) reports ECPI scores before and after treatment for two inpatients, both nearly mute and physically and/or mentally disabled, diagnosed with 'schizophrenia' and hospitalized for at least 30 years in the same psychiatric institution. They received Pre-Therapy twice a week over 7 months, as well as a constant dose of neuroleptics before and during the observed period. Additional data on the relationship between increased communicative contact and outcome are available from three single case studies with PTRS scores before and after treatment (Prouty, 1990, 1994; Prouty & Cronwall, 1990).

All clients in these studies had multiple diagnoses, including 'schizophrenia' or severe mental handicap. Pre-Therapy treatment varied from 9 months to 2 years, with up to 200 sessions. Based on the above studies, Dekeyser et al. (2008) have estimated that clients' test score after treatment was likely to be higher than 86 per cent of similar clients before treatment.

- *Comparative process-outcome evaluations* assess whether contact behaviour improves more with Pre-Therapy than with other treatments.

Hinterkopf, Prouty and Brunswick (1979) conducted a randomized controlled study on a ward for chronic 'schizophrenic' patients who had been hospitalized for on average 20 years. Seven pairs of inpatients were matched on pre-treatment PTRS scores, and one client from each patient pair was randomly assigned to either the treatment or the control group. The patients in the treatment group received 1 hour of Pre-Therapy every week for 6 months, whereas the patients in the control group received recreational therapy.

Dinacci (1997) compared the Pre-Therapy treatment of two inpatients with 'schizophrenia' (reported above) with the regular treatment of two other inpatients from the same ward, matched for age, symptoms, ECPI score and duration of stay in the institution. All four patients received a constant dose of neuroleptics before and during the observed period of 7 months.

Based on these two studies, Dekeyser et al. (2008) have estimated that the average inpatient with severe and chronic symptoms of 'schizophrenia' could be

expected to score higher on measures of contact behaviour than 74 per cent of similar patients who did not receive this treatment. These authors concluded that Pre-Therapy treatment can result in higher verbal expressivity and more meaningful communication, even in patients with 'schizophrenia' with over 30 years of hospitalization.

Contact reflections

Reflections were first introduced by Otto Rank (Rychlak, 1971) to clarify cognitive content for both the therapist and the client. Carl Rogers (1966) evolved them to include both cognitive and affective content. Eugene Gendlin (1968) conceived reflections as facilitating the experiencing process, and Pre-Therapy utilizes them for developing or restoring psychological contact. Contact reflections are a 'pointing at the concrete'. They point to the concreteness of 'schizophrenic' and brain-damaged functioning (Arieti, 1955; Gelb-Goldstein, 1966). The concreteness of the contact reflections is meant to 'meet' the concreteness of client-expression. In addition, it conveys the attitudes of unconditional positive regard and empathy (Prouty, 2001a, 2001b).

Situational reflections (SRs)

Being embedded in living concrete situations, environments or milieu constitutes our literal 'being in the world'. It implies an awareness of people, places, events and things. Accordingly, situational reflections facilitate reality contact for the client. Examples could be 'Mary pulls her hair', 'You're sitting on the floor' or 'It's a red floor.'

Facial reflections (FRs)

The human face, described as the 'expressive organ', contains not yet formed, pre-expressive affect. Facial reflections facilitate the experiencing or expression of affect. They develop the client's affective contact. An example would be 'You look sad' or even more concretely 'There are tears in your eyes.'

Word-for-word reflections (WWRs)

Many contact-impaired clients present symptoms of verbal incoherence. Such a flow of communication could be 'fire' (unintelligible), 'rat' (unintelligible), 'moon' and so on. Even though this makes no conventional sense, the social language would be reflected word for word: fire – rat – moon. Incoherent sounds are sometimes included. This approach develops communicative contact.

Body reflections (BRs)

Many 'schizophrenic' patients express bizarre body symptoms such as echopraxia (an involuntary repeating of other person's movements) and catatonia. There are two types. One is verbal – 'Your arm is in the air'; the other is literal body duplications, such as holding your arm in the air when the client does. Prouty and Kubiak (1988) present a case study using body reflections with a catatonic client.

Reiterative reflections (RRs)

Not specific techniques, these embody the principle of 're-contact'. If a particular reflection produces a response, it should be repeated, thus sustaining the contact. 'Short-term' reflections are immediate. Look, for example, at the following exchange between the therapist (T) the client (C): T: [*SR*] 'You touch the wall'; C: [*smiles*]; T: [*FR*] 'You smile; T: [*RR*] 'You touched the wall and [*FR*] now you close your eyes.' 'Long-term' reflections are at longer time intervals to 'revive' the contact. For example, T: [*SR*] 'You are holding your toy-duck in your lap'; [*SR*] 'You flip his head'; [*RR*] 'Yesterday you were holding your duck and said it was your baby.'

Box 22.2 and the following text (Prouty, 1994, 2001a, 2001b, p. 42) outline a treatment vignette illustrating the development of contact functioning. By using contact reflections and in doing so addressing the surrounding reality (RR), the spoken words (WWR), body posture (BR) and facial expression (FR), reality, affective, and communicative contact evolve into the client–therapist interaction. The client (C), diagnosed as 'chronic schizophrenic' is a hospitalized person in a long-stay facility. The therapist (T) is a student, and the narrative in Box 22.2 is written by her. This example shows the emergence of the contact functions in a therapeutic context.

Box 22.2

Contact reflections resulting in the restoration of the contact functions

C: Come with me.

T: (WWR) Come with me.

[The patient led me to the corner of the day-room. We stood there silently for what seemed to be a very long time. Since I couldn't communicate with her, I watched her body movements and closely reflected these.]

C: [The patient put her hand on the wall.] Cold.

T: (BR, WW) [I put my hand on the wall and repeated the word.] Cold.

[She had been holding my hand all along, but when I reflected her, she

would tighten her grip. Dorothy would begin to mumble word fragments. I was careful to reflect only the words I could understand. What she was saying began to make sense.]

C: I don't know what this is anymore. [Touching the wall (REALITY CONTACT).] The walls and chairs don't mean anything anymore [existential autism].

T: (WWR, BR) [Touching the wall.] You don't know what this is anymore. The chairs and walls don't mean anything to you anymore.

C: [The patient began to cry (AFFECTIVE CONTACT).]

C: [After a while she began to talk again. This time she spoke clearly (COMMUNICATIVE CONTACT).] I don't like it here. I'm so tired … so tired.

T: (WWR) [As I gently touched her arm, this time it was I who tightened my grip on her hand. I reflected.] You're tired, so tired.

C: [The patient smiled and told me to sit in a chair directly in front of her and began to braid my hair.]

(adapted from Prouty, 1994, pp. 42–3)

A web of contact

After a period of consistent empathic application of the contact reflections, a 'web of contact' is developed between client and therapist that provides sufficient communication to enable therapy. A newer example of such work is described in Krietemeyer and Prouty (2003).

In sum, Pre-Therapy (contact reflections) evolves from Rogers' conception of 'psychological contact' as the first condition of a therapeutic relationship. It describes psychological contact in terms of therapist method (contact reflections), client process (contact functions) and client measurable behaviours (contact behaviours). Pilot studies provide suggestive evidence that warrant further empirical investigation. It can also be said that the technique of using Pre-Therapy reflections is easy, but the art is difficult.

Clinical vignette

On the person-centred ward where the first author works, the goal is to practise a multidisciplinary contact milieu that on the one hand matches the ideas and practice as expressed by Prouty about working with low contact level persons, and on the other hand fits the tasks and responsibilities of the medical context. Constantly, espe-

cially as a nurse, one has to bridge a more individual-focused and experientially oriented approach with the everyday and more general concerns for housekeeping, motivating clients, receiving visitors, organizing leisure activities, administrating medication and so on (Van Werde, 2007, 2008). The following vignette dramatically illustrates a way of doing this in a crisis intervention situation in a manner that is in alignment with the formulated existential phenomenological approach. It represents the use of contact reflections in what we call 'nurses' contact work'.

Band-aid to prevent scars

The author's first-person account described the situation (Van Werde, 2008, pp. 426–9):

> In the small bureau for physical care (for activities such as for example giving injections, measuring blood pressure and so on) next to the nurses' office, a situation seems to be going out of control. A staff member comes to get me, the ward psychologist, since a crisis intervention is necessary. In the small room, on the adjustable table for medical examinations, a young man is sitting with his legs over the side and obviously very agitated about his right knee, which has already several pieces of band-aid stuck on it. A nurse, who recently joined our team and who does not have a lot of professional experience – nor any formal training in Pre-Therapy yet – is with him in the room. She is clearly intimidated by his loud insistence on an extra band-aid. So far, she has given in to his demands to apply four of them to his knee, although she cannot understand why he wants them. She is not willing to give in to his demand that yet a fifth be applied. He wants them there to prevent scars, he has told her. The nurse can't seen any wounds or scars, so his demand is clearly coming from how he pre-expressively lives his private world and tries to communicate about it, rather than from objective reality. The nurse hoped that he would be satisfied with one band-aid and would than be willing to join the others for lunch, but he has kept asking for more. When he now demands to have his knee shaved and to have a fifth band-aid applied, she has reached her limit. She had decided not to go along with that. She thinks using a razor is too risky – besides being totally unnecessary – and after all, she wants to end this confrontation.
>
> As I come in the room, the nurse steps aside and hands me the band-aid. I start doing contact work.

In the transcript below, the words spoken by the client are in italics, and the abbreviations for the types of reflection are as described earlier. The client, here called 'Chris', consented to publication of the interaction as long as we changed his name.

(Starting with an ordinary question to estimate the level of functioning.)

T. Hi Chris, what seems to be the matter?

C. *I must have a pair of scissors* (This seems like an answer to my question but at the same time it is a repetition of what he has been saying all the time. I

estimate his level in between congruent and psychotic functioning and begin applying Pre-Therapy reflections.)

T. (WWR) You must have a pair or scissors.

(SR) I see your pants on the floor, you sitting on the table, four band-aids on your knee.

C. *The band-aid must go here!* (commanding and looking at his knee)

C. *My hair must be removed!* (raising his voice)

T. (WWR) The hair should go off and the band-aid on.

C. *Stick the band-aid!* (addressing me directly)

Here it seems that his level of contact has increased somewhat; I can understand him. I pick up the affective side of the communication and give a kind of summary of what has been happening, be it in a very concrete and brief mode.

T. Seems like something very important to you, the band-aid. I heard that you also asked the nurse to stick it there (and I point at the knee).

He seems to hear me. I consequently shift the level of communication further up and try a question:

T. Why the band-aid?

C. *It has to go!*

This again is an unclear communication, so I shift back to reflecting to match his pre-expressive level:

T. (WWR, BR) It has to go and you point to your knee.

C. *No scars*.

T. (BR, WWR) I see a red spot and you say 'no scars'.

C. *The hair is growing right through it*.

T. (SR, again very concrete) I see four band-aids on your knee. I see a small red spot there, some redness there.

C. *It has to go*.

T. (WWR) … that has to go (he starts smiling) (FR) and you smile.

T. (RR, SR, RR) You smile, you look into my eyes and smile.

C. (then very serious again) *It must go on it*.

T. (SR) I'm standing here with the band-aid in my hand and you want me to stick it on. I don't know exactly why, but hear that you want me to.

C. *And it needs salve properly spread on to it, otherwise it will melt and drip from underneath it. Put it on! No scars.*

Because he is describing the care he wants, I get the impression that his level is up again and I decide to take the risk of putting the 'shared' reality gently next

to his 'private' reality of the scars and the care wanted. Crucial again is the need to stay very close to the concrete reality that is given. Still no interpretations, judgements, orders, taking over the process from my side. Meanwhile, his aggravation seems less. A bridge between different realities is beginning to form …

T. (SR) Chris, I don't see scars. I do see some redness – like a small wound that is recovering.

C. Hair grows through it and should be cut off.

T. (I closely inspect the red dot and say in a conversational mode, SR) Oh yes, I do see little hairs growing in it … (and then like a nurse that would present the realities of how to take care of a wound) … looks like it's recovering. It doesn't need salve nor band-aid. I'm sorry, I can't follow you on that.

C. (He looks at me again, seems speechless for a moment, than smiles and says) *Put it on* (… in a less harsh tone).

I repeat and thus anchor him into the reality of a situation earlier that day. He had walked into the nurses' office with a tube of salve of his own, demanding the nurse to put some salve on his temple. Later I heard that he had also complained about his two knees lowering [sic] … Again keeping very close to what had happened and again formulating in a very concrete way I say:

T. (RR) Just a while ago, you came for salve on your temple and you and the junior nurse have put it on together, here in the room, in front of the mirror … (in saying so, not limiting my understanding to this specific situation) … seems like a lot of things going on, Chris.

C. (probably, he really feels understood and his affective contact deepens) *Yes, sure!* (this makes some psychological space and I present the reality of ward life)

T. By the way, have you had lunch yet? (SR) It is ten past twelve already …

C. (he answers congruently, clearly reality contact as well as communicative contact is restored) *No, I haven't have lunch yet*.

T. Is it OK about the band-aid and can you go for lunch?

C. (He looks straight in my eyes again and says) *I don't want to look like a monster …*

T. (WWR) You don't want to look like a monster, I hear you.

Afterwards, this seemed to me the crux of what had been going on. In his pre-expressive state, he had wanted everything done to prevent him from looking a monster! Than, making some space and a bridge to another moment to address these things, if he wants to, I say:

T. If you want to, we can talk about this later. (And again offering the reality of the meal) Is it OK for you to put your trousers on again, Chris, and go for lunch?

He steps down from the table, puts his trousers on and goes for lunch.

The vignette of the interaction illustrates that 'contact' is the precondition of any (psychotherapeutic) work. The situation had come to an unbearable intensity involving anger, screaming and potentially overt aggression. As hypothesized in Pre-Therapy, when contact increases, symptomatology – conceptualized as contact loss – decreases. Once Chris felt seen and heard, once he had connected with the other person present and the surrounding reality, he was able to choose himself to cross the bridge to the other and the shared reality again. He let go of his pre-expressive and psychotically expressed demands. He consequently reconnected with the structure of ward life and went for lunch.

There had obviously been problematic pre-relational and pre-experiential functioning. Nevertheless – and it is important to realize and value this – this man had been (pre-expressively) addressing somebody else and had asked for help. It was only through the contact offer made that further escalation of 'unadjusted' behaviour was prevented. In the end, and by his own choice, he even fitted in with the structure. No violence had to be used, and there was no need to take over his psychological process.

It is important to note that the significance of this rather complex example of crisis intervention is not limited to working with people with low or borderline levels of psychotic functioning. One can easily transfer these kinds of situation to the care of people with other kinds of contact-impaired functioning such as those with special needs, and to some extent even to the care of persons with dementia, to people in a chronic situation, to people with dissociative functioning, those in palliative care and so on.

Conclusion

Prouty – touched by the suffering of people caused by troubled awareness of their material environment, frozen affective functioning and being deprived of proper social communication – formulated 'Pre-Therapy'. He defined 'psychological contact' as a precondition for any (psycho)therapeutic work and Pre-Therapy as a way of restoring contact whenever it was absent or still fragile.

Radical in its starting point of taking symptomatic functioning and individual freedom seriously, and never forgetting 'that there is always somebody in there' – as captured in the concept of 'pre-expressive functioning' – this method has proved to be a centripetal evolution of person-centred/experiential thinking and practice.

Points for reflection

- How do you think that it is possible, if at all, to bridge a non-directive philosophy with the demands of everyday life in a residential or custodial context?
- How relevant do you think that Pre-Therapy might be to other contexts, such as clients in palliative care settings?
- Could you imagine yourself using Pre-Therapy reflections in your practice at moments of contact loss?

Key readings

- For up-to-date data concerning developments in Pre-Therapy and a complete list of references on the subject, see www.pre-therapy.com, hosted by the Pre-Therapy International Network (founded in 1985 by Jill and Garry Prouty, and coordinated since by the first author and yearly bringing together some core European members).
- Besides the above-mentioned references on well-documented applications in fields of care of people with special needs (see also Krietemeyer & Prouty, 2003; Peters, 1999; Poli, 2005; Pörtner, 2002, 2005) and psychotic individuals (see also Sommerbeck, 2003, pp. 68–173), there are two newer volumes on Pre-Therapy: Prouty (2008) and Sanders (2007). The former, edited by Prouty and sampling 'emerging developments in Pre-Therapy', documents its expansion beyond itself to a second generation of theorizing and applications. The latter, a most accessible, easy-to-read but comprehensive introduction to the subject introduces a new term – 'contact work'. This term not only encompasses the psychotherapeutic pure and classical systematic and intensive use of the Pre-Therapy techniques, but also described translations and applications of this way of looking at and working with contact-impaired functioning to different levels, diverse settings and client groups, thus defining a broadened concept.
- Topics that have been addressed in the literature on Pre-Therapy and contact work so far are as diverse as, for example, working in home situations (Clarke, 2005, pp. 16–17; McWilliams & Prouty, 1998), working with people who tend to dissociate and have other trauma-related functioning (Coffeng, 2005), music therapy (Leijssen, 2000), remedial education (Ondracek, 2005, pp. 391–4), and the field of dementia (Dodds, 2008a, 2008b; Dodds et al., 2004; Van Werde, 2002b; Van Werde & Morton, 2002).
- Van Werde, coordinator of the Pre-Therapy International Network (dion.vanwerde@sint-camillus.be) and a close associate of Prouty for many years, describes Pre-Therapy in everyday practice in residential psychiatric care for people suffering psychotic functioning (Van Werde in Prouty et al., 2002, pp. 61–120; Van Werde, 2002a, 2005, 2008). This represents a translation of Pre-Therapy into the creation of a multidisciplinary contact milieu. Dierick (2010) likewise integrates Pre-Therapy into residential care for the elderly.
- A welcome overview of early research on Pre-Therapy can be found in Dekeyser, M., Prouty, G., & Elliott, R. (2008). Pre-Therapy process and outcome: A review of research instruments and findings. *Person-Centered and Experiential Psychotherapies*, *7*, 37–55.
- Research has been conducted introducing Pre-Therapy into dementia care and its subjective reception by caregivers (Dodds, 2007, 2008a, 2008b), as well as how these caregivers describe welcomed changes in their practice (Pfeifer-Schaupp, 2007, 2008). Brooks and Paterson (2011) and Carrick (2011) heuristically explore what Pre-Therapy has to offer to working with people presenting an autistic spectrum disorder. Brenner (2006) explores this in the field of working with people with special needs.

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Note

The passing of Garry Prouty (1936–2009) is, needless to say, for many reasons a great loss.

23
Difficult client process

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This chapter discusses:

- 'Process' within person-centred theory
- Difficult process as an alternative way of thinking about clients who have traditionally been diagnosed with severe disorders
- How process and relationship capacities develop – and how they may develop strongly or be thwarted – as an addition to Rogers' developmental theory
- Fragile process, in which individuals have difficulty holding experience in attention, modulating the intensity of experience and receiving others' experience without feeling that their own experience or sense of self has been annihilated
- Dissociated process, in which individuals convincingly experience themselves as having quasi-autonomous selves not integrated with each other for periods of time
- Research relating to the development of process and relationship capacities in the attachment relationships of early childhood

Most clients find the experience of being understood within a genuine and prizing relationship to be comforting and satisfying, even when dealing with challenging and painful issues. While the experience of person-centred psychotherapy is seldom easy, most clients, in my experience, find a flow between changes in their moment-to-moment experience and their development of new understandings. Such understandings become integrated into an evolving sense of self. And these sorts of changes naturally generate the exploration of new life choices. Clients' immediate process, their sense of having a solid and integrated self and their sense of personally grounded agency each develop and mutually strengthen each other.

But with some clients, the experience of psychotherapy is much more difficult, whether for the clients themselves, for their therapists or for both. Such difficult process can endanger clients' ability to continue in therapy at all or can lead to unnecessarily intense crises and hospitalizations. Clients' experience may be difficult in several interrelated ways – in clients' ability to process immediate experience, in their ability to hold a sense of self and in their ability to make congruent life choices. Difficult process is not offered as a way of diagnosing of persons, since particular clients may experience more than one form of difficult process. Or they may experience difficult forms of process to different degrees. They may find their process difficult in some aspects of their experience but not others.

I have identified three forms of difficult process in my own practice – 'fragile process', 'dissociated process' and 'psychotic' process'. I am sure that other forms of difficult process could be identified as well. In my view, psychotic process is addressed very well through the work of Garry Prouty (see Prouty, 1994, and Chapter 22). In this chapter, I will confine myself to discussing fragile and dissociated process. Also, for the sake of brevity, I am discussing difficult client process at an individual level, even though a great deal could be said about difficult process as it plays out in relationships, groups and societies.

Therapists from more diagnostically inclined orientations are likely to apply quite severe diagnoses to clients who are experiencing such forms of difficult process – such as narcissistic personality disorder, borderline personality disorder or dissociative identity disorder (American Psychiatric Association, 2000). Some theorists see these clients as being particularly likely to be tricky or manipulative, or as wanting at some unconscious level to create pain and confusion in the therapist (see, for example, Kernberg, 2000; Ogden, 1977). Although person-centred therapists may be able to recognize behavioural aspects of these diagnostic categories in their clients, they are likely to think about these clients very differently from the ways in which therapists from other orientations think. And they approach the therapeutic relationship with these clients in a very different way.

In conceptualizing difficult forms of process, my own intention is not to alter or add to Rogers 'necessary and sufficient conditions' of psychotherapeutic change. I find a classically oriented, non-directive style of psychotherapy particularly helpful in working with these clients. Rather, I am hoping to add to the therapists' repertoire of understandings in such a way that they may be more attuned in their empathic understanding and more genuine and prizing in relationships with these clients. In addition, I hope to raise therapists' awareness of sensitivities that many clients have about how empathy is expressed when they are in the midst of difficult process.

In my experience, significant numbers of clients who are experiencing difficult forms of process feel much safer and less stigmatized in person-centred therapy than they do in other forms of psychotherapy because of the higher levels of control that they have over the content, structuring and timing of psychotherapy, and because of the personally connected, relatively non-hierarchical nature of the therapeutic rela-

tionship. For some clients, person-centred psychotherapy seems to be the only form of therapy that they can tolerate (Box 23.1).

Box 23.1

Carol's experience of therapy

'Carol' had several breakdowns and hospitalizations while seeing therapists practising in more interpretive and structured styles of practice. In spite of the fact that she had recently completed a doctorate, she ended up living at home with her parents, unemployed and massively in debt from the cost of the hospitalizations. And since her initial breakdowns were triggered by therapeutic interactions, she was terrified at the idea of seeing *any* mental health professional. She only came to me because a close friend said to her 'Believe me, this client-centred therapy will be different from anything you have experienced before.'

When Carol first came to see me she was frequently hallucinating corpses, guns and car crashes while having near-constant suicidal impulses. Her work with me has been difficult and intense, but we have been able to work with her experiences collaboratively and without hospitalization. While she is likely to continue in therapy for a long time, the intensity of her symptoms has greatly lessened. She has been able to find work, moving from minimal levels of pay and status to jobs with increasing levels of responsibility within her field. She has recently passed the exams that let her practise within her profession and is working in a full-time job that uses her skills.

The sorts of structuring, intervention and interpretation offered in other orientations can, I believe, easily intensify the volatility of difficult clients' experiences. This, I think, leads clients to many of the behaviours that therapists then think of as 'tricky and manipulative'. Yet when more directive therapists have intervened in ways that increase client volatility and distress, they often think of this as a characteristic of the client rather than seeing themselves as playing a significant role in stimulating the client's reactions.

In spite of my general, positive assessment of client-centred therapy, I do not think that a client-centred orientation *automatically* results in therapists being good at establishing effective therapeutic relationships with clients experiencing difficult process. I have come to think that person-centred therapists' having some repertoire of understandings about common ways in which difficult process is experienced by clients is crucial. Often, I think that this sort of sensitivity makes the difference between success or failure in working with these clients. To explore the nature of difficult forms of process, let us first consider the concept of 'process' within the person-centred tradition.

What is process?

In the person-centred tradition, 'process' refers to characteristic ways in which human experience goes through spontaneous and self-directed changes within relationships that are genuine, empathic and prizing. Rogers (1961, pp. 129) notes that:

> I wish I might share with you much more fully some of the excitement and discouragement of this effort to understand process. I would like to tell you of my fresh discovery of the way feelings 'hit' clients – a word they frequently use.
>
> The client is talking about something of importance, when wham! He is hit by a feeling – something not named or labeled but an experiencing of an unknown something which has to be cautiously explored before it can be named at all. As one client says, 'It's a feeling that I'm caught with. I can't even know what it connects with.' The frequency of this event is striking to me.

Rogers delineates a continuum of 'process,' crediting the joint work of Eugene Gendlin, William Kirtner and Fred Zimring in these initial conceptualizing efforts. The proposed continuum goes 'from fixity to changingness, from rigid structure to flow, from stasis to process' (Rogers, 1961, p. 131). Gendlin (1964, 1968, 1995) has greatly deepened person-centred theory relating to process, creating a philosophically sophisticated account of experiencing and the creation of meaning.

Process, as described by Rogers, Gendlin and others, involves a set of changes that ultimately allow individuals to come to articulated versions of their life situations that give them a whole-body sense of personal rightness. As such, experiences shift and become clearer, and they tend to become integrated with a person's overall sense of self, creating an overall 'congruence' within the person's experience. Such increasing levels of congruence tend to bring higher levels of agency – an ability to make choices and take actions that fit with the whole person.

After delineating the continuum of fluidity and immediacy of client process, and noting that higher levels of process seem to be associated with success in psychotherapy, Rogers asks 'Is this *the* process by which personality changes or one of many kinds of change? This I do not know' (Rogers, 1961, p. 155, original emphasis). In earlier writings, Rogers (1951) observes that productive client experiences are not *always* tied to the kind of process that he commonly observes in therapy sessions:

> therapy can move forward even though outwardly the client exhibits very few of the elements which we have thought of as characteristic of therapeutic progress … it seems more likely that the outcome was due to an experience in a relationship … One hypothesis is that the client moves from the experiencing of himself as an unworthy, unacceptable, and unlovable person to the realization that he is accepted, respected, and loved in this limited relationship with the therapist. (p. 159)

This suggests a complex relationship between unconditional acceptance – which may be healing in itself – and the self-directed processing of experience that tends to emerge within person-centred relationship.

Difficult process and person-centred theory of development

This conceptualization of difficult process does not challenge Rogers' (1957) theory of the 'necessary and sufficient' conditions of therapeutic personality change. It does, however, offer an additional dimension to Rogers' theory of development. In Rogers' (1951, 1959) theory of personality change, he suggests 'conditions of worth' in childhood as the primary source of incongruence and psychopathology in clients (see Chapter 8). Such conditions of worth have to do with significant others in individuals' childhoods having communicated that some of their real or potential ways of being are unworthy of positive regard and with individuals having internalized these attitudes.

I am suggesting that, in addition to *attitudes* about particular ways of being, young children have a tendency to develop a closely intertwined set of processing and relationship *capacities*. Like Rogers' famous potato trying to grow towards a distant source of light, the development of these capacities may be thwarted by less than optimal early childhood circumstances or be the result of a variety of sorts of biological factors. Despite this, these capacities are so fundamental to the human organism and its tendency to actualize that they will continue trying to develop throughout a person's lifetime. With less than optimal development (or later impairment), these processing and relationship capacities will continue to function, albeit in ways that tend to be difficult for all involved. Person-centred therapy offers a particularly sensitive and safe holding environment for moment-to-moment processing and relationship. It also opens a path for the ongoing development or re-establishment of these very fundamental human capacities.

Several sorts of capacity that develop within the attachment relationships of early childhood seem particularly central to people's later abilities to process personal experience and their ability to engage in mutually satisfying relationships. These are the capacity (1) to hold experience in attention, (2) to modulate the intensity of experience, and (3) to name experience in a way that resonates with the totality of the person's lived experience. Good-enough development of these three capacities seems to allow the development of a fourth capacity – the capacity to take in the experience of another person without feeling that one's own experience has been annihilated. These capacities are initially managed in a partnership between a caregiving adult and the child. Under optimal conditions, the young child gradually internalizes all of these as relatively autonomous capacities.

Holding experience in attention

Infants left to themselves become cranky very quickly – they are not very good at keeping a pleasurable focus of attention on their own. Yet, from their earliest days, infants seek out the faces of adults. Fogel (1982) finds that, in the first year of life, securely attached infants stay engaged with pleasurable interactions for longer and longer periods of time. Numerous studies have shown that the parents of securely attached infants show high levels of moment-to-moment attunement, both in initi-

ating interactions and in responding to distress (Sroufe, 1996). On the other hand, the caregivers of less securely attached infants tend to be non-responsive or to respond in ways that leave the infant frustrated or overstimulated.

Modulating the intensity of experiences

Of course, infants initially have almost no capacity to modulate the intensity of distress on their own. If a baby is cold and wet and hungry, and no adult comes to help, the experience quickly comes to feel like torture. Ideally, adults come and take steps to alleviate any sources of bodily distress experienced by an infant, as well as engaging the infant in pleasurable non-verbal interactions. Schore (1994) notes that, through repeated experiences of arousal increase and modulation, the brain increases its ability to dampen high arousal and to regulate emotion in general. The orbital, prefrontal area of the brain, which allows a young child to shift from high to low levels of arousal, undergoes a spurt of growth during the end of the first year and into the second year of infancy (Schore, 1997; Sroufe, 1996).

As a result, securely attached infants learn that bodily felt experience is by and large a good thing, and that interactions with others tend to make experience more manageable and more pleasurable. Less securely attached infants seem to come to an opposite set of learnings: that it is difficult to maintain emotionally engaged attention in a way that leads to sustained positive experiences; that situations of high arousal are likely to lead to overload and disorganisation; and that caregivers are not very effective in soothing distress when it does occur.

Naming experiences

Initially, an infant's experience is intensely felt in an immediate way that is, of course, completely non-verbal. Gendlin (1964) calls these implicit meanings:

> the 'implicit' or 'felt' datum of experiencing is a sensing of bodily life. As such it may have countless organized aspects, but this does not mean that they are conceptually formed … we complete and form them when we explicate. (pp. 113–14)

Early on, most parents begin to engage in a particular sort of empathic interaction in which they begin to name the infant's experiences and to offer hypothesized reasons for these experiences – perhaps saying that the baby is 'tired' when she cries or that she thinks 'spinach is disgusting' when she spits it out. Essentially, parents are offering verbal symbols that *could* carry the infant's implicitly felt experience forward into explicit meaning if the infant had words. At some point, children come to recognize a matching or mismatching between words and own felt experience. Of course, there is great variation in the quality of parental empathy in this early naming of infant experience and the clarity of reasons offered for such experiences. Such experiences that have never been received empathically in childhood are likely to feel unreal, or in some mysterious way bad or poisonous to the person as an adult.

Coming to understand and respond to others' experiences

As children grow older, they are increasingly expected to respond to the demands of others and to understand others' experiences. From observing clients, I have come to a core processing observation. This last ability – the ability to take in the experiences and perspectives of other people – is dependent on the earlier development of processing capacities. If a person has difficulty holding a key experience in attention, moderating its intensity or naming the experience, he or she is very likely to have great difficulty shifting attention to *anything* from the frame of reference of other people without great distress. It is important to note that this is different from the situation in which a person could understand another's experience but does not because of selfishness or emotional laziness. If people are in the midst of fragile process, they *cannot* take in other people's experience without having the sense of annihilating their own.

Trauma and the development of processing capacities

Extreme or repeated experiences of trauma tend to interrupt the development of all of the above processing-relevant capacities. Trauma floods the child with experiences that cannot be handled, often in circumstances in which relevant adults are unwilling or unable to accurately name the circumstance the child is facing.

Fragile process

Individuals who experience what I call 'fragile process' have difficulty in controlling the intensity and focus of their experience (Warner, 2000; Box 23.2).

Box 23.2

Fragile process

Individuals experiencing fragile process are likely to have difficulty:

- holding experience in attention without extreme vulnerability or shame;
- modulating the intensity of experience;
- starting and stopping experience;
- naming phenomena in ways that fit with the totality of their experience;
- taking in the experience of others without feeling that their own experience and sense of self has been annihilated.

This takes a number of forms. Clients in the midst of a fragile style of processing tend to experience core issues at very low or high levels of intensity (Warner, 2000).

They tend to have difficulty starting and stopping experiences that are personally significant or emotionally connected. In addition, they are likely to have difficulty taking in the point of view of another person while remaining in contact with such experiences. I am not referring to more moderate levels of emotional distress here. These are moments in which the client's core experiences come with an intensity that is hard to control, often combined with very high levels of vulnerability and shame. In the midst of these experiences, the client is unable to take a broader perspective without a sense of personal annihilation. Most people experience fragile process at the most vulnerable edges of their experience. Some people experience fragile process in relation to a large number of personal experiences, so that it affects large parts of their lives.

For example, a client may talk about day-to-day events for most of a therapy hour and only connect with an underlying feeling of grief at the very end with the sense that she could sob forever. At this point it, may be exceedingly difficult for the client to stop the session and to go out into the world alone, much less return to work. Clients with low-intensity fragile process are likely to experience personal reactions as subtle emotional shadings, as threads of experience that they can barely catch and hold onto. Yet if they do touch them, they feel intensely shameful and hard to stay with. If distracted or contradicted, they are likely to give up on the idea that such experiences have any significance. Clients experiencing a high-intensity fragile process feel their experience as overwhelming and potentially never-ending. A person may feel a bottomless well of sadness, or anger so overwhelming that the person might destroy his or her surroundings.

Because of this vulnerability to volatile, shameful, personally overwhelming experience, clients often live with a considerable barrier between their daily living and their responses to core emotional issues. Or they may live very volatile, chaotic lives. In either case, if some life situation or some therapist response touches fragile issues, their reactions may instantly become overwhelmingly present with high levels of vulnerability and shame.

Empathic understanding responses (see Chapter 11) are often the only sort of responses people can receive while in the middle of fragile process without feeling traumatized or disconnected from their experience. The ongoing presence of an accepting, empathic person can be essential to the person's ability to stay connected without feeling overwhelmed. If a therapist is able to stay with the client's experience in a way that is sensitive and attuned, this can help the client to stay with the experience him- or herself with less sense of shame and isolation. Being responded to by a trusted, empathic person can help the client tolerate the level of intensity and/or bring the intensity to a somewhat more moderate level. In a certain sense, clients in the middle of fragile process are asking if their way of experiencing themselves at that moment has a right to exist in the world. Any misnaming of the experience or suggestion that they look at the experience in a different way can be experienced as an answer of 'no' to the question.

This brings a crucial choice in work with clients in the midst of fragile process. Therapist comments, interpretations or structured interventions may intensify fragile

process in a way that feels extremely overwhelming and shameful to the client, while at the same time making it difficult for the client to receive or understand experiences from the therapist's perspective. In this sort of situation, clients may experience ruptures in their relationships with therapists and be drawn to a variety of self-destructive behaviours as they attempt to respond to their high levels of distress. Object relations therapists such as Kernberg (1984, 2000) tend to accept or even stimulate these sorts of escalation of feeling and the related blocking of understanding of other's perspectives by the client. Rather than avoiding these escalations, they are likely to use the feelings stimulated in the client and in the therapist as an occasion for interpretation.

Theorists in the client-centred tradition, on the other hand, propose that processing capacities have a natural and spontaneous tendency to develop under facilitative relationship conditions even much later in life (Warner, 2000). Frequent or severe escalations of misunderstandings between client and therapist, rather than being a useful ground for interpretation, are seen as having the potential to interfere with this sort of natural process development. Empathic responding allows clients to stay in contact with fragile experience while minimizing ruptures in the therapeutic relationship. Self-psychology theorists, while not addressing process directly, make a similar point in talking about the development of self–object functions (Kohut, 1984).

Therapists often greatly underestimate how sensitive clients are when they are in the middle of fragile process. In general, client-centred therapists focus on empathic responding and avoid even moderately directive questions, suggestions or interpretations. Yet, at vulnerable moments, a client may need even more precise forms of empathic understanding responses – for example, the client may need to hear the therapist's understanding in almost his or her exact words to feel understood. Or, when a client is attending to something that is unclear, open-ended words like 'something' or 'somehow' may let the therapist 'make space' for the unclearness in what the client is saying without adding any contrary meaning. Take, for example, this dialogue between a client (C) and a therapist (T):

C: The situation at work is a hopeless weight on my life.

T: A hopeless weight. Something about that whole situation at work is a hopeless weight.

C: Yes, exactly. [*cries*]

Even paraphrasing a client's words may result in her losing the ability to hold the experience, and lead to a feeling that the experience (and possibly her self in relation to the therapist) has been annihilated – leading the client to feel enraged or to give up on the interaction and withdraw. For example:

C: The situation at work is a hopeless weight on my life.

T: You feel really frustrated at work.

C: I DIDN'T SAY I FELT FRUSTRATED!!! WHY DID YOU SAY THAT??? YOU DONT UNDERSTAND ME AT ALL.

Even more so, therapist comments that are intended to be helpful and to advance the client's self-exploration may backfire. For example, the client might simply disconnect from feeling and comply with the therapist:

C: The situation at work is a hopeless weight on my life.

T: Why do you feel that way?

C: Well, I suppose I shouldn't feel that way, doctor. You know more about these things than I do. Should I just act more cheerful???

The risk here is that therapists can easily see clients' anger or withdrawal as the client's problem – without seeing that the therapist's behaviour has a great deal to do with the client's response. Therapists assume that clients could turn off fragile process if they wanted to, and then proceed to view clients as tricky or manipulative.

Dissociated process

Clients who experience 'dissociated process' (Warner, 1998, 2000) quite convincingly experience themselves as having selves that are not integrated with each other for periods of time. This sort of client experience has been described at length in the literature on 'multiple personality' and 'dissociative identity disorder', and virtually always results from severe early childhood trauma (Putnam, 1989; Ross, 1989; see also self-plurality in Chapter 8).

In response to such traumatic experiences, children split experience into separate personas. At such early ages, children have high levels of hypnotic suggestibility. Faced with overwhelming trauma and lacking the more complex ways of coping with experiences that are available to older children, our clients seem to have stumbled on dissociation as a solution. One client, for example, found that when she stared at dots on the wallpaper, she could separate herself out from the terror and anguish of being raped by her father. Some clients describe experiencing themselves as out of their bodies and watching the events from the ceiling.

Understandably, dissociation in these circumstances is extremely reinforcing.

Children go from an extreme of anguish to a lack of intense pain and an ability to put the whole thing out of their minds the next day. Typically, our clients describe having felt helplessness, terror, pain and anguish that were so intense they felt that they could die from those feelings. In this, they simultaneously felt afraid of dying yet wished that they could die. They felt intense rage and wished that they could do violence to the perpetrator. Despite this, they wished that they could hold on to the times when their parents seemed loving or nurturing.

In the helpless part of their feelings, they were terrified of the violence of their angry feelings. From the angry part of their feelings, they felt disgust and shame at their reactions of helplessness. In their wish that they could hold on to some normal life, they wished that both the angry and the helpless, anguished reactions would disappear. Probably as a result of these contradictions, a number of different clusters of experience separated out within their dissociated experiences. These clusters of experience came to

have a very distinctive sort of 'person-like' experience of themselves, each with their own feelings, history and way of looking at the world.

Clients may experience the edges of these personality parts as quite aberrant experiences – such as hearing voices, seeing altered versions of reality or having odd body sensations. Alternatively, they may sense them as personas acting within them over which they have little control. For example, one client said to me 'I didn't come to this session, the child part brought me.' Or if they switch into a personality part, they may experience the therapy situation almost as if they were a different client. So the fact that one part of the client knows and trusts the therapist does not necessarily mean that another personality even knows who the therapist is, much less trusts her.

Several key points emerge here. Trauma issues that need to be resolved are held within personality parts that are quite separate from the client's everyday persona. So deep change will not happen unless the client feels safe enough to let him- or herself connect with these separated personality parts. The edges or the first manifestation of these alternate personas may seem quite psychotic – the client may hear voices, have unusual body experiences, see things and the like. Experiencing the edges of personality parts, the client may be afraid of going crazy – so it is important that the therapist is not alarmed by the experiences. Very close empathic responding to these 'psychotic-like' experiences at the edge of dissociated personas often lets the client stay with them and open them up to change. In addition, connecting with the parts is ultimately the client's strongest route to healing.

These parts are separate enough that ultimately the therapist will do well to think of the relationship almost as if it were family therapy – with each personality part being equally valuable in its attempts to cope with an impossible childhood situation. If the client feels safe with the therapist, alternate personas are likely to begin to manifest themselves on their own – both because there is an inner impulse to integrate experiences and because life circumstances are likely to trigger responses from these different parts (Box 23.3). Inside the personality parts, the client is likely to feel a great deal of fragile process.

Box 23.3

Marian's experience of therapy

Marian was a recent college graduate who was having trouble holding a job that fitted her educational level and had issues relating to a number of volatile relationships. She said a number of times that 'I've put the pieces on the table. You have to pick them up.' For months, I had no idea what to make of this comment. When I was away on vacation over the summer, I began to wonder if it was possible that the pieces she was talking about could be alternate personalities or 'parts'. When I returned in the fall, I was much more attuned to subtle hints about parts experiences, and, I think, as a result, Marian began to talk about her experiences much more openly.

At Marian's initiative, we developed a style of working in which I held her hand and gave relaxation instructions. She would then 'switch' into much younger alternate personalities who had images from the time of her mother's death when she was 18 months old. Throughout the years of Marian's therapy, I neither tried to get alternate selves to emerge nor did I try to stop them or diminish the intensity of their experiences. I simply stayed very close to her immediate experiences.

Sometimes she talked about day-to-day issues that had little obvious connection to the dissociated parts. At other times, she talked about manifestations of parts that confused her (people she had never heard of called and talked as if they knew her well, clothes showed up in her closet that she didn't remember buying …). Sometimes parts emerged in the session in rapid succession and talked in opposition to each other. Often, she would not remember these sessions within her everyday personality. Sometimes Marian would say, 'It must have been a wonderful session. I don't remember a thing about it.' After one session, Marian said, 'I had this very weird experience after our last session. After I left the building I was a male person and I got into a red sports car and drove off.' (Marion's actual car was a gray sedan.) 'I came to myself at my house several hours later, but I have no idea what happened in the time in between.' Through all of these experiences, a picture began to emerge of severe trauma in her childhood, which some parts wanted to talk about and other parts thought should never be touched.

One day Marian said, 'The strangest thing happened. Five parts snapped together into one; I've never experienced sadness and anger at the same time before.' Over time, she found herself needing to switch into parts less and less, until she spent almost all of her time as a single integrated personality. In the process, her life stabilized in many ways. She established a stable partnership with a woman and had a beautiful commitment ceremony. She has also completed a graduate programme in the social services and has been very effective and satisfied in her work.

When therapists can connect with these various personas, the client may be able to process the original trauma. And as the trauma is less frightening, the personas have less need to stay separate from each other and the person is likely to reintegrate into a single personality.

Since dissociative experiences are often foreign to the therapists, I have found that that they often normalize the client's experiences without realizing it (Warner, 2000). Clients often initially experience or express this radical split in their subjective sense of self in somewhat indirect ways, such as:

- Actions without a sense of the client being the author. For example, a client might say, 'My hand wants to pick up the knife.'

- Feelings without context, as when a client says, 'I was walking down the street and suddenly started sobbing for no reason.'
- Vagueness about what happened for periods of time. For example: 'I guess I must have been really out of line. That whole afternoon isn't too clear in my memory, but everyone seemed angry with me afterward.'
- Voices. For some clients these are experienced clearly whereas for others they are blurred together, sounding somewhat like a radio in the background.

Any of these types of experience could be aspects of non-dissociative processes or just said in a metaphoric or joking way. Yet, if the therapist is able to respond in an accepting and accurate way – often needing to stay very close to the client's exact words – alternative personas or 'parts' that do exist will tend to emerge more clearly. For example, if a woman client says, 'I feel like those last words just came out of my mouth. I don't know where they came from,' a therapist could easily respond 'You're surprised to find yourself saying that.' Staying closer, a therapist might say, 'You really feel that those words just came out of your mouth, somehow. You don't know where they came from.'

This sort of difference in wording may seem subtle. But if the client is experiencing dissociated parts, the first response is likely to convince her that the therapist is unwilling or unable to understand the degree to which dissociated experiences coming from one part are experienced as out of the control of another part. The second response provides an opening for her to say more if she wants to. The client may then say things that more clearly indicate the degree of autonomy such personas have. For example, she might then say something like, 'I have this strange feeling that there's a part of me that knows more than I'm ready to know about what happened with my stepfather. I'm afraid that she'll take the session over and I'm not ready to handle what she has to say.' Richard Bryant-Jefferies (2003) has written a fictionalized account of work with a client in the midst of dissociative process that captures a great deal of the way such work feels in actual person-centred practice.

Long-term benefits of work with difficult process

Client-centred therapists have come to a number of conclusions in working with various kinds of difficult client process. Experiences that initially seem most difficult and irrational are often central to the person of the client; the therapist cannot skip them without taking away the client's core self. Yet attempts to direct or explain or to teach different ways of being with these experiences often backfire – clients withdraw, or become more distressed or at risk of hurting themselves or others.

On the other hand, we have found that if it is possible to stay connected with difficult client process in a sensitive way, this often relieves the stress and aloneness that clients are feeling. When therapists can stay with client experiences, clients become more and more able to stay connected to these experiences themselves. This allows experiences to process and resolve themselves. And, over time, when therapists

and clients are able to connect with difficult process in a safe relationship, the processing capacities themselves tend to develop and become stronger. Clients tend to:

- stay more connected to experiences of distress without being totally shamed or overwhelmed by the experience;
- let more experiences come so that insights emerge about experiences that had previously seemed private and shameful;
- begin to move out of the 'tunnel vision' of their own initial reactions, becoming able to take in other people's perspectives;
- become increasingly able to engage in work and in personal relationships in productive and mutually satisfying ways.

Even if there is physiological damage that is irreversible, processing capacities develop to the extent that this is physically possible. Often clients develop alternate pathways that allow them to process to a significant degree.

Conclusion

Deep changes in 'difficult process' require relatively long, empathically sensitive therapeutic relationships. Yet, in considering the extent of this investment, it is important to remember just how personally debilitating difficult process is in the lives of clients. Clients in the midst of difficult process have high risks of suicide, extremely high levels of personal distress, loss of the ability to work and loss of the ability to maintain personal relationships. Taken together, the effects of difficult process can be as debilitating and as life-threatening as suffering a heart attack or cancer. Therapeutic work can be life-saving and seems well worth the cost.

Points for reflection

■ As a client-centred therapist, I would like to be able to say to a client, 'I think I can stay with you pretty much wherever your experience takes you.' Do you think that you can stay with clients in the midst of the various forms of difficult process described in this chapter? Do you have any idea what you would need inside you to help you be able to do this? Or do you have ideas for how to be with clients if you are honestly unable to stay with particular aspects of difficult process?

■ I suggest that once I really understand what difficult process is like for clients, I will almost never think of them as 'tricky' or 'manipulative' or dependent'. Rather I will see them as struggling as best they can to handle a process that is difficult. Do you agree? Do you think you are able to do this?

■ Clients in the midst of difficult process sometimes ask for more than other clients do – for longer sessions, for telephone calls in between sessions, for answers to personal questions. More flexibility can be helpful to these clients, but too much flex-

ibility may leave the therapist incongruent. Do you think you are able to be clear what sorts of flexibility you are genuinely able to offer?

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The person-centred approach as it illuminates various issues relating to human nature.

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24
Working with traumatized clients and clients in crisis

LORNA CARRICK AND STEPHEN JOSEPH

This chapter discusses:

- The premise that when we are most challenged, we often find new and fulfilling directions in life
- Recent developments in the field of psychology which recognize that traumatic events can often be the springboard to growth
- The person-centred approach to working with clients in crisis

A crisis may be defined as an acute state of distress wherein one's usual coping mechanisms have failed in the face of perceived challenge or threat, resulting in some degree of functional impairment. Prompted by a single threatening life event such as a violent attack, an accident, rape or the death of someone close to them, or ongoing events such as difficulties at work or relationship problems, individuals can enter a state of crisis.

For several decades, psychologists and other helping professionals have been interested in how best to intervene with those who are in a state of crisis, but the roots of this field go back further to the middle of the twentieth century. The development and practice of crisis intervention, and what has come to be called critical incident stress debriefing, date back to the work of Caplan (1964) and colleagues at the Harvard School of Public Health. However, the most significant impetus for research was the introduction in 1980 of the diagnostic category of post-traumatic stress disorder (PTSD) into the third edition of *The Diagnostic and Statistical Manual of Mental Disorders*.

Although not everyone is in agreement over the value of psychiatric classification,

the introduction of PTSD led to the development and provision of services in response to crisis, specifically the development of trained crisis intervention teams, and the development of critical incident stress management techniques. Such techniques are used to help people in the immediate aftermath of trauma by providing psychoeducational support to prevent the occurrence of later problems, and to provide guidance on what to do if problems do arise. For those for whom problems do arise, new developments in therapies for the treatment of PTSD followed (see Joseph, Williams, & Yule, 1997).

Historically, little has been written on crisis and trauma from a person-centred perspective. Studies that refer to using the person-centred approach as crisis intervention have used the term in the broadest sense, for example the use of pastoral care as crisis intervention (Hart & Matorin, 1997). The prevalent perception is that person-centred therapy is not the treatment of choice for working with clients with severe and chronic psychological problems, but this view has come to be challenged in recent years (Joseph & Worsley, 2005).

Understanding traumatic stress

Since the introduction of PTSD, a vast literature has developed on how people react to crisis events and why some are more vulnerable than others to their negative effects. Some people are more able to cope in challenging situations and recover relatively quickly. Others remain affected for considerable periods of time, perhaps developing problems of depression, anxiety or post-traumatic stress. Major theories of post-traumatic stress account for individual differences in response through the interaction of past experiences in life, personality factors and ways of coping, influenced by how the person appraises the event.

Rogers, of course, developed his theory of person-centred psychopathology long before the introduction of PTSD, and thus does not use the term. As such, person-centred theory has received little attention from traumatologists. However, a closer inspection of Rogers' theory shows that it provides an account of traumatic stress processes compatible with modern trauma theories (see Joseph, 2003, 2004, 2005).

When Rogers introduced the concept of the self-structure, he provided the basis for understanding crisis and trauma from the person-centred perspective. Rogers believed that, given the right therapeutic conditions, clients are intrinsically motivated to integrate self with experience (Rogers, 1951, 1957, 1959; see also Chapter 8). Experiences that are incongruent with the self-structure are subceived as threatening, and therefore clients will avoid an accurate symbolization of the threatening experience. This clearly describes the opposing processes that are at work in processing trauma. Clients are motivated on the one hand to accurately symbolize experiences as evident in their intrusive thoughts, and on the other to avoid all reminders. A typical response from a client might be: 'I can't believe this is happening to me.' Or 'I can't believe he is gone.'

Rogers (1959, p. 201) described the process of breakdown and disorganization of the self-structure in which 'an experience is perceived or anticipated, subceived as incongruent with the structure of the self', and that 'psychological maladjustment exists when the organism denies to awareness significant experiences'. Breakdown and threat may also be experienced when individuals deny to awareness significant experiences that threaten their worldview, such as a crisis event. In an attempt to hold the dissonance between self-concept and experience, the client may talk from different parts of the self, for example 'Part of me knows I need to get over this, but there's the other bigger bit that just feels so hopeless and scared, I can't even think about it.' Here the client is attempting to avoid exposure to the subceived threat and is at the same time experiencing the urge to move beyond the crisis state, to process the experience. It is only when accurate symbolization of experience occurs that reconfiguration and integration can take place and post-crisis growth is possible.

Post-traumatic growth

Post-traumatic growth provides a new paradigm for understanding reactions to trauma, in which the person-centred approach provides the basis for a new theoretical understanding and way of working therapeutically. 'Post-traumatic growth' refers to three broad, but related, dimensions of positive change. First, relationships are enhanced in some way, for example in that people now value their friends and family more, and feel an increased compassion and kindness toward others. Second, people change their views of themselves in some way, feeling, for example, that they have a greater sense of personal resiliency, wisdom and strength, perhaps coupled with a greater acceptance of their vulnerabilities and limitations. Third, there are reports of changes in life philosophy, for example finding a fresh appreciation for each new day or shifts in understanding of what really matters in life (Tedeschi & Calhoun, 1995, 2004).

Extending person-centred theory to the study of post-traumatic growth, the organismic valuing theory stems from a person-centred approach and states that humans are intrinsically motivated towards growth (Joseph, 2011; Joseph & Linley, 2005, 2006) (Box 24.1). It is proposed that trauma challenges the assumptive world but that humans are intrinsically motivated to accommodate the new trauma-related information. However, the direction of accommodation can, in terms of the values and meanings that are attached to the accommodation process, be either negative or positive. Cognitive accommodation requires the person to re-experience and confront the meanings of their experience, which can be distressing, resulting in the process of working-through, which consists of alternating states of intrusion and denial. In this model, post-traumatic stress is seen as a normal and natural process that triggers post-traumatic growth. Organismic theory provides an understanding of post-traumatic stress as the engine of post-traumatic growth.

Box 24.1

The person-centred approach to crisis intervention

The person-centred approach works from a potentiality model, believing that the self-curing capacities of the client are a formidable resource (Taylor, 1983). Historically, the medical model has responded mainly to the danger in crisis and less to the opportunity for change, and has consequently looked to therapeutic models that offer symptom reduction and cognitive reframing. However, trauma researchers are, as we have seen, beginning to recognize the potential for post-traumatic growth and the fit with the person-centred approach.

The person-centred approach to working with crisis involves the therapist in following the client cognitively, and emotionally facilitating the accurate symbolization of both realms of experience. Mearns and Thorne (1988, p. 104) state that 'the very activity of empathic understanding often has the effect of diffusing a crisis, of slowing it down and relieving to some extent the crippling effect of anxiety and dread which the client may be undergoing'.

Qualitative research (Carrick, 2007) into the perceptions of experienced person-centred therapists of what helps clients in crisis identified three main elements that therapists saw as different in their work and helpful in relation to crisis. First was the *quality of connection* with the client. From the first session, therapists described these clients as 'wide open, raw and defenceless' and as '*having no choice*'. This, they believed, created the possibility for deep levels of engagement much sooner. Second, *not changing the crisis* or trying to take the client back to pre-crisis functioning was seen as very important. These therapists had a strong sense of the possibility of change and post-crisis growth. Third, facilitating this change happened through the *symbolization of experience*, involving high levels of empathic attunement, exploring what this was like for the client and even deepening the experience, while providing a sense of holding and accompaniment.

These therapists described a much more intentional response towards their clients when they identified a 'crisis marker': they chose reflections that assisted symbolization of the traumatic elements of experience, at the edge of awareness, when the usual defences were failing, thereby helping the client to change by processing the new information provided by the traumatic event. Perception of a 'therapeutic marker' for crisis (Elliott, Watson, Goldman, & Greenberg, 2003) seems to evoke a 'differential response' (Purton, 2004) in which therapists describe themselves as using more energy and being more 'highly charged' (Carrick, 2007) than with non-crisis clients.

Client safety, sufficiency of therapeutic context and the extra demands that working with clients in crisis places on the therapist all require consideration. Assess-

ment is a term often avoided in the person-centred approach (Wilkins, 2005), but in crisis intervention it is necessary to assess from a phenomenological standpoint the sufficiency of the context in which the work takes place and whether the client requires a wider contract. For example, it may be necessary to reconsider the frequency of sessions, the availability of emergency contact numbers and other information (Mearns, 2003).

Good supervision is essential as the potential for over- or underinvolvement is paramount in crisis intervention. Counsellors who feel overwhelmed by the depth or nature of the client's crisis may choose not to engage fully and may be underinvolved. Overinvolvement may lead to trying to 'fix' the client or attempting to rescue them. Trainee counsellors may fail to recognize the possibility of post-traumatic growth that crisis creates and be either drawn into overinvolvement or paralysed by the client's need to be fixed. In the person-centred approach, the therapist seeks to follow the client's lead offering acceptance of the client in the crisis state.

Crisis intervention demands a great deal of the therapist, particularly in extreme cases where the dissonance may be so great that the client arrives in a state of dissociation. In this state, the client can be seen as having multiple 'selves', which may or may not be aware of each other's existence (see Chapter 23). Engaging fully with the client may involve the therapist in tapping their own self-experiences of crisis. Mearns and Cooper (2005) refer to these self-experiences as 'existential touchstones'. These touchstones are experiences that form the milestones in the development of each of us: coping with puberty, facing the death of someone we love, coping with embarrassment or experiencing powerlessness. Person-centred therapists may use their own personal touchstones to get a deeper sense of their client's experience, and in doing so go beyond simply tracking and understanding the client. Touching one's own experience of crisis may seem particularly dangerous if there is a fear of being overwhelmed. It is therefore particularly important that these touchstones are fully explored in supervision or therapy and in contexts that help therapists to learn to use them therapeutically.

The case of Jenny

We will illustrate how the person-centred approach can help people in a state of crisis using the case of Jenny. Prior to the onset of crisis, which involved a breakdown of both the client's self-concept and her existing worldview, Jenny described herself as a quiet, respectable married woman of 50 with two grown-up children, a nice house and a stable yet unromantic marriage. Her husband was a businessman and a leading figure in a religious community. Her doctor's referral was marked 'extremely urgent' and cited marital breakdown and complete breakdown of normal functioning as the key issues. Jenny looked frozen on arrival at our first session. She was dressed in an outfit that would suit someone much older. Jenny described herself as feeling completely lost and hopeless and experiencing severe panic.

The following dialogue comes from Jenny's first session with the therapist (LC), taken from extensive therapy notes:

Jenny: [*looking at LC and wringing her hands*] I have never been for therapy before. Will it work quickly? [*tears begin to fall*] I am not coping with anything.

LC: You are feeling that you want this to make things better quickly and wanting some reassurance that therapy will work?

Jenny: I need you to tell me what to do. I can't function like this. My husband has been having an affair and is leaving me. I can't believe it! I have never been on my own and he always promised to look after me. I have been a good wife to him and done everything he asked. He says I am boring and unattractive and that he wants someone who will make him feel good. [*sobbing*]

LC: Right now you really can't make sense of what has happened. You don't know how you will cope alone and you can't believe he would go away with someone else and just leave you. You just want to feel better.

Jenny: Yes, I don't know if I am strong enough to cope, and I feel so stupid I didn't see what was happening; he was just using me and he didn't love me. He's always looked after himself. All I wanted was to have a nice family and a good home. I never felt pretty or exciting. I always felt I had to please him. He often said that no one else would want me. I felt safe as long as he was there. Now I just want to curl up and die.

LC: Nothing was as it seemed, and it has made you want to curl up and die.

Jenny: I can't go back to where I was before.

The therapist reflects the client's 'shattered assumptions' (Janoff-Bulman, 1992, p. 1) and the threat to her life picture, and chooses to assist the symbolization of the depth of the crisis rather than the content of what the client has said.

Jenny's father had died when she was only 12 years old, and as a result she had experienced rapid change at that time and considerable hardship. She had been forced to wear very plain, handed-down clothes as her mother struggled to support her and her older sister and brother. Jenny was expected to support her mother and put her own needs last. This earlier crisis had helped to create a self-concept that was modest, hard-working, self-effacing and obedient, and led to the development of her desired life picture, which was financially secure and respectable. Jenny described her pre-crisis self as a happy young girl who loved to sing and dress up. The new crisis evoked painful memories and a fear of being out of control.

LC: I sense that you are afraid just now of not being able to control your life and of going back to a position where you don't have the resources you need to live.

Jenny: When you say it like that, it sounds so clear. I am like that frightened girl of 12 who lost her lovely Daddy. Now I am going to lose my husband and that frightens me [*pause*] and I don't even know if I love him any more.

Reflection of her fears helped Jenny to begin to symbolize aspects of her life that she was avoiding. Feeling understood and accepted in therapy helped Jenny to search for a way of understanding herself, making a 'new life picture' that did not include her husband or some aspects of her previous self-concept.

Jenny: Everything seems so uncertain I don't even know who I am any more. How am I supposed to go on? It is so long since I was just me, not Philip's wife or May and John's mother.

LC: This change is so big that it is making you wonder who you are.

Jenny: Yes I have never asked myself that before! … Maybe there is more wrong than I thought. No one is interested in who I am.

LC: Perhaps we can find out as we work together?

Jenny: You are not going to tell me how to fix this. [*smiles*]

The therapist stayed with, and even emphasized, the depth of the crisis. Symbolizing the subceived conditionality of her relationship helped Jenny to see how this had made her vulnerable. She then seemed calmer and more ready to approach her fears (see Box 24.1 above).

Between sessions, Jenny reported re-running the events leading to her feelings of fear and panic that were evoked by images, so overwhelming, that she would furiously clean her house or dig the garden as a distraction. When this happened, disturbing dreams and memories of events from her marriage that she had suppressed were now remembered with clarity. Jenny felt sadness and indignation at the way she had allowed herself to be treated. She oscillated between rumination and avoidance of these aspects of her experience.

LC: You seem really tense today?

Jenny: I have been desperate to get here this week. It's like someone took the lid off my life, and all the things I didn't want to see have escaped.

LC: You are really anxious when you see all the things that you would rather had stayed hidden?

Jenny: Yes, the really troublesome bits, I don't like to look at them when I am alone. When I think of Philip leaving, I panic like a little girl who still wants her Daddy.

LC: You want to feel safe again as you did when you were young. Would you like to look at the things that frighten you with me?

Jenny: Oh yes!

Exploring her fears of not coping helped Jenny to acknowledge that, in the absence of her husband, she could cope when the children needed her, and that she had a growing set of recognizable skills that could not be attributed to anyone else. This awareness came about through a process of symbolizing both her fears and her ability to cope under pressure, and challenged her self-concept in a growthful way, requiring her to incorporate the coping part of herself in her self-concept.

Jenny then reported the following in session six:

Jenny: You won't believe what I have had to deal with this week. John [*her son*] stopped going to college and wouldn't get out of bed. He was crying all the time because his father is selling our house and he is scared that we will have nowhere to live. So I told him that I would find us a new home. I just held him and then went out to find to a lawyer to ask about my rights. Six weeks ago, I could not have gone there because lawyers frightened me, and he [*the lawyer*] was very nice and it turns out that we will be fine; we will have to move house, but the new house will belong to me.

LC: You coped with all the emotion at home and the practical steps you needed to take, and your voice sounds different when you say that.

Jenny: I feel stronger now … and I have a voice.

Jenny symbolized herself as having been wounded by the loss of her father and marrying a man who was not interested in her needs. Symbolization of her experiences though empathic tracking and focusing responses helped her to work on material that was approaching the edge of her awareness. Jenny acknowledged that she felt safe enough to review her life with 'her eyes open' in therapy. She became less self-critical, developed more empathy for herself and began to see a new life picture that gradually included a new part of herself which she identified as being her 'own safe keeper'.

Jenny's appearance also underwent significant changes. This seemed to be a physical manifestation of her changing sense of self and the world: she became more sociable and less fearful, visiting friends and joining clubs. When I noticed these differences, she responded with feeling:

Jenny: I have not had a good life in many ways; [*my husband*] was not good to me. Now I want to find out what I can be like on my own. One day, I saw this dreary woman in the mirror and she didn't look interesting or friendly. Then I thought about the 12-year-old girl that you helped me remember in that first session. She loved nice things and smiled a lot. I tried smiling at the mirror and then at other people and saw the difference. I actually felt less depressed and more alive. I decided that even though this was not my choice, I can make the best of it. I will be a woman of colour and fun … I hope.

This new life picture was more realistic in that it was open to her 'troublesome bits' and was less afraid to cope with life, and, more significantly, the process of symbolization had produced a desire to change.

The rapid changes in Jenny mirror the experiences of the research participants in the study of person-centred working with clients in crisis (Carrick, 2007). The therapists saw crisis as speeding up the process of therapy. For Jenny, there is growth in terms of how she thinks of herself, in her relationship to the world and in her approach to relationships with others.

Good practice within the person-centred approach to crisis

Working with clients in crisis presents the therapist with a unique challenge and opportunity. There is an opportunity to meet the client where the usual defence structures have failed and they are both vulnerable and wide open to change. Jenny's rigid self-structure and worldview prior to the crisis made it unlikely that she would change. So much of her energy went into maintaining the status quo in her marriage. She was unhappy and did not want to approach the threatening incongruence between her picture of her marriage and the reality of a dysfunctional relationship. She was anxious and depressed prior to the onset on crisis. Only when evidence from the external environment presented a challenge so profound to her assumptions about how she was living her life did the coping mechanisms of denial and distortion break down, initially leading to distress but then, as she worked though the significance of what had happened, creating the opportunity for post-traumatic growth.

Horowitz (1976) has proposed that people have mental models, or beliefs, about the world that they use to interpret their experiences, and that there is an inherent drive to make our models coherent with current information in what he called the 'completion principle'. This drive to make sense of challenging new information as it comes into awareness and to create a set of 'total, organized, goal-directed responses' (Rogers, 1951, p. 485) fits well with person-centred theory.

Jenny's case illustrates how events that challenge the person's assumptive world or, in person-centred terms, threaten the self-concept may bring about a crisis that effectively breaks down the client's rigid self-structure. The need to resolve the information related to the new trauma with respect to the assumptive world leads to post-traumatic stress processes as the person struggles to regain their homeostasis, but it also creates the opportunity for post-traumatic growth. The person-centred approach aims to facilitate post-traumatic growth through closely following the client as the various parts of her self-structure reconfigure to 'a different point of homeostasis, a different balancing point' (Mearns, personal communication, 2005).

Like many clients who arrive for counselling very early in the post-crisis process and who have not yet developed PTSD, Jenny initially showed signs of both avoidance and intrusion. Most people experience some degree of post-traumatic stress, but it is only when the problems become so overwhelming, so emotionally disruptive to everyday functioning, that the diagnosis of PTSD is warranted. Organismic theory suggests that some degree of post-traumatic stress indicates that the person is attempting to work through their experience. Offering high levels of the core conditions and not trying to change the crisis may assist the client to continue to symbolize their traumatic experience by providing a sense of safety, acceptance and companionship, which may be helpful as a means of helping the person process their experience.

The principal task of therapy is to assist the client to accurately symbolize their experience (Rogers, 1951). Crisis intervention involves ensuring more accurate symbolization at a point where the client seems closer to his or her own existence and open to change. Clients will often say, 'I just want to get back to normal' even when

normal was a maladaptive way of being. Human beings seek familiarity and homeostasis. It seems that nothing is more threatening than inconsistency and destabilization of the self-structure. What crisis does is to create such a tension between the self-structure and experience so that the individual senses or subceives the need for change. This sense, which is often on the edge of awareness, comes with a sense of threat.

As such, it is important to be able to provide empathic affirmation in order to facilitate accurate symbolization. The client in crisis requires to be held, metaphorically, in their experience, by the therapist while in such a vulnerable state. The closeness and connectedness of this relationship can often lead to moments when client and therapist meet at what Mearns and Cooper (2005, p. 1) describe as 'relational depth' very early in the therapeutic process. The working alliance between client and therapist is essential at this stage. Clients describe these moments in terms such as 'feeling really seen', 'feeling as if you [the therapist] are part of me' and, in the case of one client, 'I feel as if you are a safe extension of my thinking and feeling space.'

Conclusion

Traditionally, trauma has been studied through the lens of the medical model, but with the emergence of post-traumatic growth as a new field of research and practice, interest in the application of the person-centred approach is growing (Joseph, 2011). Future developments in the person-centred approach to crisis intervention might well take their lead from the exponents of process-experiential therapy, where research into effectiveness with specific psychological difficulties has been developing in recent years (Elliott et al., 2003), and from developments in process work (Worsley, 2009). Although the non-directive attitude is core to person-centred therapy, much is now known about the general psychological processes that people go through following crisis and trauma, and the factors that aid recovery and promote post-traumatic growth. In this respect, the person-centred therapist can draw on these other resources of knowledge. While believing that the client remains the best expert on themselves – the content of what they are experiencing and the process they are going through – attention to how clients process traumatic material can support full engagement in crisis work.

Points for reflection

- Is person-centred therapy always helpful for people who are traumatized?
- Is there a difference in the process of change when the need for therapy is activated by trauma?
- How important is the concept of post-traumatic growth in relation to this client group?

Key readings

■ Joseph, S. (2011). *What doesn't kill us: The new psychology of posttraumatic growth*. New York: Basic Books.

Joseph provides an up-to-date review and a new theoretical framework based on person-centred psychology, and for clients useful self-help material is also included.

■ Joseph, S., & Butler, L. D. (2010). *Positive changes following trauma*. National Centre for PTSD Research Quarterly, summer, 2010. Retrieved from www.ptsd.va.gov/professional/newsletters/research-quarterly/V21N3.pdf (accessed November 2012).

A useful source of information that is free to download.

■ Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.

Tedeschi and Calhoun originated the term 'post-traumatic growth' and have been pioneers in the theory and clinical applications of the field.

■ Turner, A. (2012). Person-centred approaches to trauma, critical incidents and post-traumatic stress disorder. In J. Tolan & P. Wilkins (Eds.), *Client issues in counselling and psychotherapy* (pp. 30–46). London: Sage.

This chapter provides some very useful material, including some good case illustrations.

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25
A person-centred approach to addiction treatment

J. Roland Fleck and Dorothy T. Fleck

This chapter discusses:

- A history of the perspectives on addiction
- Contemporary approaches to the treatment of addiction
- Motivational interviewing as a person-centred approach to addiction treatment
- Generic user-friendly strategies consistent with the spirit of both person-centred therapy and motivational interviewing

Addictive disorders are among the most commonly diagnosed disorders in Western culture. Unfortunately, by the time most people receive treatment, the disorder may be quite advanced and have become the source of physical, psychological, social and legal problems for the person. For many people, treatment may be a matter of life or death. Yet addictions are very treatable, and success rates are comparable to treatment results for other psychological disorders. Most people who seriously seek treatment recover, and the results of effective treatment can be quite dramatic.

There are a number of addiction treatment approaches that work, and there is now greater understanding of what contributes to their effectiveness. It is clear that the similar elements in the various addiction treatment approaches are far more significant than the differences. Research consistently concludes that therapist and client factors are far more important than treatment techniques. Who you are and how you relate to your clients is far more important than what you do. Therapists who can establish constructive therapeutic relationships that are high in the expression of Rogers' conditions of accurate empathy, congruence and unconditional positive regard are the most effective. In this chapter, we will provide a rationale for

the use of motivational interviewing not as traditional client-centred psychotherapy but as a collaborative application of Rogerian-based person-centred therapy in the treatment of addictive disorders. In addition, specific user-friendly strategies that are consistent with both the spirit of motivational interviewing and person-centred approaches are articulated.

Brief history of perspectives on addiction

There has been considerable controversy in Western culture regarding the development of addictions in people. Thombs (2006) discusses three perspectives on how addictions develop: addiction as immoral conduct or sin; addiction as a disease; and addiction as a maladaptive behaviour. The immoral conduct perspective places blame on the alcoholic or drug addict for freely choosing to not abide by the accepted norms of society, and views punishment as the logical 'treatment' for the addicted individual.

The disease perspective views the compulsive use of alcohol, other drugs or addictive behaviours as symptomatic of an underlying illness that, at least in part, has genetic origins. This perspective moves addictions out of the realm of sin and recommends compassionate treatment since the drinking, drugging or addictive behaviour is beyond the control of the individual. The 12-Step Recovery Movement is rooted in this disease model of addiction.

Finally, the maladaptive behaviour perspective views addictions as learned behaviour – 'problem behaviour that is clearly under the control of environmental, family, social, and/or even cognitive contingencies' (Thombs, 2006, p. 8). This problem behaviour is not viewed as either sinful, out of control or freely chosen, but the addicted individual is instead seen as 'a victim of destructive learning conditions' (p. 8). This perspective employs learning strategies in treating the addictive behaviour, including contingency management, modelling, social skills training, assertiveness training, behavioural self-control training and overall relapse prevention skills training (Lewis, Dana, & Blevins, 2011).

Miller, Forcehimes and Zweben (2011) present six models in discussing the aetiology of addictions: personal responsibility models, agent models, dispositional models, social learning models, sociocultural models and a public health model:

- *Personal responsibility models* are very similar to the immoral conduct perspective described by Thombs (2006), in which addictive behaviour is freely chosen despite its violation of legal, moral and/or religious principles.
- *Agent models* place the blame on exposure to the drug or addictive behaviour and emphasize reducing availability and criminalization.
- *Dispositional models* are very similar to the disease model described by Thombs and see the cause of addictions as constitutional and not under the control of the individual. Treatment involves taking personal responsibility and is generally abstinence-based, for example using 12-step programmes.
- *Social learning models* are similar to the maladaptive behaviour perspective described

by Thombs and focus on learned experience as the cause of addictions. 'Interventions from a social learning perspective focus on changing the individual's relationship to the social environment' (Miller et al., 2011, p. 26), and include the interventions listed above under the maladaptive behaviour perspective.

- *Sociocultural models* further broaden the aetiology of addiction by focusing on societal and cultural factors and the expectancies and norms regarding addictive behaviours that are created by social policies, advertising and media programming.
- Finally, a *public health model* is articulated which integrates all of the important factors from the first five models. This model considers the interaction of the drug or addictive behaviour (agent), the individual (host) and the environment. This public health model is a balanced approach to addiction treatment that allows for greater sophistication in the planning of interventions.

Contemporary approaches to addiction treatment

There is an abundance of empirical evidence that addiction treatment works with a wide variety of clients, under different conditions and using a variety of treatment methods (Berglund, Thelander, & Jonsson, 2003; Imel, Wampold, & Miller, 2008; Mee-Lee, McLellan, & Miller, 2010; Miller, 2009). In fact, a Rand Corporation study (1994) found that the cost-effectiveness ratio of addiction treatment was 7:1, with $7 saved in crime-related costs for every $1 spent on addiction treatment.

Project Match is the largest study to date comparing the effectiveness of alcohol treatment methods (Babor & Del Boca, 2003; Project MATCH Research Group, 1997). Three different manual-guided individual treatment approaches were compared over a 12-week period: cognitive-behavioural therapy (Kadden et al., 1992), motivational enhancement therapy (Miller, Zweben, DiClemente, & Rychtarik, 1992) and 12-step facilitation therapy (Nowinski, Baker, & Carroll, 1992). Using 1,726 randomly assigned participants, all three treatment methods produced positive and largely equivalent outcomes in both an outpatient setting and an aftercare setting following intensive inpatient treatment: 'Significant and sustained improvements in drinking outcomes were achieved from base line to 1-year post-treatment by the clients assigned to each of these well-defined and individually delivered psychosocial treatments' (Project MATCH Research Group, 1997, p. 7). Miller et al. (2011) report that 'clients' outcomes were reasonably stable across 3 years of follow-up, with relatively little loss of post-treatment improvement' (p. 126). Ten-year follow-up data demonstrate no differences in treatment results comparing cognitive-behavioural therapy, motivational enhancement therapy and 12-step facilitation therapy, and the 'gains that were achieved during the first year after treatment were sustained on an overall sample level to the 10-year follow-up' (Tonigan et al., 2003, p. 1).

The meta-analysis performed by Imel et al. (2008) analyzed 30 studies (47 effects) that employed widely varying approaches to alcohol treatment including '12-step facilitation therapy, motivational enhancement therapy, behavioural self-control training, Alcoholics Anonymous, aversion therapy, relapse prevention and

dynamic therapy' (Mee-Lee et al., 2010 , p. 399). The results clearly demonstrated that there were no significant outcome differences between a wide variety of bona fide treatment approaches for alcohol use disorders. This result is consistent with psychotherapy research in general, which has consistently supported the finding of a lack of treatment difference results when bona fide psychotherapies are compared (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997; Wampold, 2001).

Rogers' necessary and sufficient conditions

A preponderance of evidence clearly indicates that therapist and client factors are much more significant than treatment approach. Miller et al. (2011, p. 49) state that 'effective addiction treatment is not just a matter of *what* you do, but is also strongly influenced by *who* you are and *how* you work with your clients'. Rogers (1957) was the first to articulate this distinction in his paper 'The necessary and sufficient conditions of therapeutic personality change', stating that effective therapy is dependent upon the existence of six conditions (see Part II). The first condition (client vulnerability) would appear to be a precondition for all effective therapy including addiction treatment; this demands engagement with the client and the establishment of a collaborative relationship. Conditions 3–5 are considered the core conditions and elaborate the therapist conditions that are critical for producing growth and change in clients: empathic understanding or accurate empathy; therapist congruence, genuineness, honesty and authenticity; and therapist unconditional positive regard, consistent acceptance, and non-possessive interpersonal caring and warmth (Merry, 2004; Rogers, 1961).

Evidence-based treatments

Empathic understanding, or accurate empathy – the ability to respectfully understand the world from the client's perspective or internal frame of reference – is a very strong predictor of therapist effectiveness in treating addictions (Miller & Baca, 1983; Miller, Taylor, & West, 1980; Miller et al., 2011; Valle, 1981). In fact, it can be said that accurate empathy on the part of the therapist is one of the most validated evidence-based interventions used in the treatment of addictions (Norcross, 2002; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010).

There has been considerable research on identifying evidence-based treatments for addictive disorders. These treatments include brief interventions such as FRAMES (*feedback* to the client, client personal *responsibility*, clear *advice*, a *menu* of options, an *empathic* counseling style, and the encouragement of *self-efficacy*), motivational interviewing, cognitive-behavioural therapy, strengthening coping skills, community reinforcement and contingency management, behavioural marital therapy, 12-step facilitation therapy, and mutual help groups such as 12-step groups (Miller, 2009; Miller et al., 2011). However, as noted earlier in this chapter, the results of meta-analysis indicate no difference in the effectiveness of these various addiction treatment approaches (Imel et al., 2008).

These addiction treatment approaches are effective because of the therapists who use them. Therapists differ considerably in their effectiveness, and 'variability in outcomes attributable to differences between therapists appears to be considerably larger than variability attributable to differences between treatments' (Zuroff et al., 2010 , p. 682). Zuroff et al. further conclude that 'there appears to be robust evidence that variability between therapists in the capacity to establish constructive therapeutic relationships is a key predictor of outcomes' (p. 692). Constructive therapeutic relationships were defined as therapist–client relationships with high levels of the Rogerian conditions of empathy, positive regard and congruence. It is clear that empathy is 'a quality that clients want in their therapist, above and beyond the type of treatment they receive' (Miller et al., 2011, p. 51).

Addiction treatment approaches that contain high levels of empathic understanding are in strong contrast to approaches to addiction treatment in which there are low levels of empathy (Valle, 1981) and, in many cases, harsh confrontational approaches designed to break down the perceived resistance in the client. These approaches were very popular from the 1960s into the late 1980s in the USA and still are found in some psychosocial rehabilitation centres and therapeutic communities. However, most addiction treatment centres have changed from this personal confrontational approach to a more respectful self-exploration approach, most often based upon 12-step groups where participants work the steps under the guidance of a sponsor. The research findings on the use of an aggressive confrontational treatment approach have consistently found that at best it is ineffective, and at worst it is harmful to a large number of clients (Miller & White, 2007). Owing to the fact that the successful treatment of addictive disorders can be a life or death issue for a significant number of people, it is critical that these individuals be treated with respect and not be discouraged from seeking further treatment by inhumane, harsh, confrontational treatment approaches.

Transtheoretical stage of change model

A major factor that influenced the transition from a harsh confrontational approach to a more respectful humane approach in addiction treatment in the late 1980s and early 1990s was the formulation of the transtheoretical stage of change model (Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992). This model clearly delineated how readiness for change differs significantly in clients and affects their motivation for change. Prochaska and DiClemente (1984) postulated the change process as a sequence of five stages through which people advance as they create, modify or stop behaviours. People who make behavioural changes:

> move from being unaware or unwilling to do anything about the problem to considering the possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time. (DiClemente, 1991, p. 191)

The stage of change model is conceptualized as a cycle of change in which individuals usually move back and forth between the stages and progress at different rates (Center for Substance Abuse Treatment, 1999):

- *Precontemplation:* There is no recognition of a problem and no intention to change. The focus of therapy is to work with the client to create ambivalence about the necessity of change.
- *Contemplation:* There is recognition of a problem and consideration about overcoming it, but no commitment to take action or change. The focus of therapy is to help the client move toward change by resolving the ambivalence.
- *Preparation:* There is an intention to change the behaviour and initial formulation of a plan to act. The focus of therapy is to collaborate with the client in developing and committing to a change plan.
- *Action:* There is the implementation of a plan to stop the old behaviour pattern and begin to engage in the new behaviour. The focus of therapy is to collaborate with the client to put the change plan into action.
- *Maintenance:* There is the consolidation of the new behaviour change and its integration into the lifestyle of the individual. The focus of therapy is to collaborate with the client to stabilize the behaviour change and avoid relapse (Prochaska et al., 1992).

Motivational interviewing: a person-centred approach to addiction treatment

Since 1991, when William R. Miller and Stephen Rollnick published their groundbreaking book on the use of motivational interviewing in working with addictions, there has been an increased emphasis on using a person-centred approach in the treatment of addictive disorders (Miller & Rollnick, 1991, 2002). Motivational interviewing is defined as 'a goal-directed, client-centred counseling style for eliciting behavioural change by helping clients to explore and resolve ambivalence' (SAMHSA's National Registry of Evidence-based Programs and Practices, 2007). Miller and Rollnick have recently updated their definition of motivational interviewing to 'a collaborative, person-centered form of guiding to elicit and strengthen motivation for change' (Miller & Rollnick, 2009, p. 137). It is strongly rooted in the client-centred or person-centred theory of Carl Rogers (1957, 1959, 1961, 1989) and is by far the most widely used and researched person-centred approach for the treatment of addictions, with over 200 randomized clinical trials on it (Miller & Rollnick, 2010a). Miller and Rose (2009, p. 12) state that 'motivational interviewing is a psychotherapeutic method that is evidence-based, relatively brief, specifiable, applicable across a wide variety of problem areas, complementary to other active treatment methods, and learnable by a broad range of helping professionals'.

There are four guiding principles of motivational interviewing, described below, that are considered far more important than any specific strategy or technique used in therapy (Miller & Rollnick, 2002).

Express empathy

Expressing accurate empathy is at the heart of motivational interviewing and the foundation for facilitating change in the client. It is essential in developing a collaborative therapist–client relationship, and communicates respect and a strong interest in understanding how the client perceives the world and, more specifically, the particular presenting issue. The use of non-judgemental reflective listening communicates therapist presence to clients as the therapist accurately reflects back a respectful understanding of what was communicated. In addition, non-judgemental reflective listening allows clients to experience and clarify their own internal processes in a non-judgemental fashion (Miller et al., 2011).

Develop discrepancy

Motivational interviewing postulates that clients are more likely to respond positively to their own words than to what a therapist tells them. The therapist focuses on the discrepancy between the client's current behaviour and their ideal or desired behaviour. It is client ambivalence about this discrepancy that motivates behaviour change. Therapists can use such interventions as looking back with the client to a time when things were different, or looking forward to what the client would like the future to look like. The goal is to have the client present the arguments for change. 'When skillfully done, motivational interviewing changes the person's perceptions (of discrepancy) without creating any sense of being pressured or coerced' (Miller & Rollnick, 2002, p. 39).

Roll with resistance

The therapist perceives resistance, sometimes referred to as countermotivation, as an indication that the client has a different perspective on the situation, and considers this ambivalence to be a normal part of the process of change. Client responses such as arguing, interrupting, denying and ignoring are typical signs of resistance but are never directly confronted by the therapist. Instead, the therapist would use interventions such as various types of reflective listening, shifting focus or reframing to roll or flow with the resistance in order to create a new momentum toward changing the behaviour. The focus is always on the clients being the primary resource for producing change talk that moves them in a new direction.

Support self-efficacy

The therapist's belief in the clients' capacity for change is a critical factor in clients feeling empowered and developing a belief in their own capacity to successfully make changes. In fact, client self-efficacy is a good predictor of positive treatment outcomes. If clients do not believe in their ability to make changes, it is likely that no signifi-

cant efforts towards change will be made, and the work of the therapist on the previous three guiding principles of motivational interviewing will be of limited usefulness. The old idea of ready, willing and able being foundational to the change process is probably more accurate if reversed. Change probably more readily occurs when the client first feels able (a sense of self-efficacy) followed by being willing and then ready. Collaboratively exploring with the client past successes and identifying the next manageable step can be useful interventions in supporting self-efficacy.

The four guiding principles of motivational interviewing lead to a collaborative therapy process in which the client provides the content and the therapist guides the process. Motivational interviewing is also a culturally neutral style of relating to clients if the four guiding principles are followed since the focus is on evoking from the client what is already there rather than imposing something on clients:

> Motivational interviewing honors and respects the individual's autonomy to choose. It is a collaborative, not a prescriptive, approach, in which the counselor evokes the person's own intrinsic motivation and resources for change. Implicit is the belief that such motivation and resourcefulness do lie within each individual and need to be evoked rather than imposed. (Miller & Rollnick, 2002, p. 41)

Five strategies of motivational interviewing

Miller and Rollnick (2002) describe five specific strategies or early methods that they recommend using from the very beginning of therapy. These first four methods or strategies are derived from person-centred therapy and focus on 'helping people to explore their ambivalence and clarify reasons for change' (p. 65). They are identified by the acronym OARS:

- Use open questions
- Affirm
- Reflect
- Summarize.

The fifth method or strategy, evoking change talk, is unique to motivational interviewing and is the guiding strategy employed by therapists in the resolution of client ambivalence.

Use open questions

These are questions that cannot be easily answered with a brief reply and that invite the client to explore. It is important that therapists communicate a willingness to listen closely to clients' responses and allow clients to tell their story. For example:

- I'd like to understand how you see things. Can you tell me more about what brought you in today?

- You indicated that there have been some prior treatment attempts. Can you tell me more about those?
- You stated that you have been drinking for about 8 years. Why don't you start from the beginning when you started to drink and bring me up to date?
- You mentioned that your family has expressed some concerns about your drug use. Can you elaborate on their concerns?

Affirm

This is a method for helping clients to recognize their strengths, motivations, intentions, efforts to change and progress. It builds rapport, reinforces client exploration and promotes self-efficacy. It is important to look for ways to show appreciation and affirm even the smallest efforts and successes, past or present, on the part of clients. Rogers (1961) was very clear in his belief that criticism and lack of affirmation block change, while clear acceptance and affirmation provide the freedom necessary for change to occur in the client. For example:

- I have enjoyed talking with you today and really appreciate how open you have been with me about your drinking.
- It certainly took a lot of courage for you to decide to do something about your drug use.
- You have come in with some great ideas on how to reduce your gambling.
- You are certainly a very strong person to have lived with this problem for such a long time, and I can really sense your commitment to deal with this problem in a positive way.

Reflect

Reflective listening is probably the most critical OARS skill, and the focus is on how the therapist responds to what the client is saying. The therapist decides what to respond to (reflect) and what to ignore. The therapist listens carefully to what is being said by the client and then makes a reasonable guess as to what the client means before voicing this guess in the form of a statement, not a question. It is like coming up with a hypothesis about what the client is stating and a means to check whether you truly understand what the client means; encourage the client to let you know whether you have correctly reflected the proper meaning. It is a primary way of building a collaborative empathic therapeutic relationship that fosters motivation for change. For example:

- It sounds like you are not ready to quit drinking.
- It sounds like you are saying that you are considerably more relaxed since coming to the treatment centre, although you have some concerns about all the decisions that lie ahead.
- It sounds as though your wife is more concerned about the amount of your gambling losses than you are.

- I get the sense you are feeling a lot of pressure from your family to quit drinking, and you are not sure you can deal with life without drinking.
- It sounds as though smoking weed is one way you use to temporarily escape from the stressors in your life.

Summarize

Summary statements are a means of pulling together a number of related things, linking a statement the client has recently made with something said in the past, or transitioning from one topic to another. Summarizing allows the therapist to focus on critical issues or shift attention or direction. In addition, it allows the opportunity to focus on any change talk the client has made and to examine client ambivalence about change. For example:

- It sounds like you are pulled in two directions. On the one hand, you are worried about the effect that drinking is having on your children. At the same time, you are concerned about how you could live without drinking.
- Our session is just about over, so let me see if I understand so far what you are saying to me … Here is what I have hear so far … Have I missed anything?

Evoke change talk

Rather than lecturing clients or reasoning with them about the importance of changing their behaviour, the therapist's guiding strategy is resolution of ambivalence by facilitating the client's expressions of personal concern about the behaviour and intentions and arguments for change. The goal is to have the client express the need for change rather than the therapist advocating for the change, as is done in more confrontational approaches. The therapist should listen carefully to the client and provide prompt recognition of any type of self-motivational statements made by the client. Client statements representing change talk include:

- statements that indicate recognition of the problem;
- statements that indicate concern about the problem;
- statements that indicate commitment to changing the behaviour;
- statements that indicate a belief that changing the behaviour is possible.

Methods for eliciting change talk includes the first four strategies elaborated above (that is, use open questions, affirm, reflect and summarize). There are additional methods including the following (Miller & Rollnick, 2002):

- Asking evocative questions
- Using the importance or confidence ruler (scale)
- Using the decisional balance (pros and cons)
- Asking for elaboration
- Using extremes

- Looking back
- Looking forward
- Exploring goals.

Generic-user friendly strategies

Fleck and Fleck (2005) have described what they refer to as generic concepts that provide user-friendly terminology to teach beginning strategies that are consistent with the spirit of motivational interviewing. Since most people who enter treatment for addictions are at least referred if not mandated by the courts, these issues are a part of the following discussion.

Use respectful understanding

Begin where clients are in order to engage them. Use reflective listening to encourage clients to express their unique perspective on how they got referred to treatment, and how this view may differ from that of the referring party. Respectful understanding does not mean agreement with the client, and it is not only possible, but actually more effective, to accept a person's thoughts and feelings without agreement or approval. For example: 'So you don't think the social worker who is investigating your case has a clear understanding of all the pressures you've been under. Tell me more about that.'

Look for common ground with clients

This does not mean that you necessarily identify with the client's particular struggles or that you necessarily use self-disclosure to connect with the client. Common ground can be simple generic types of experience such as the fact that you both grew up in New York City or that you both like Italian food. Encourage discussion of these common-ground experiences to allow the client to perceive you as an approachable person, to relax with you, and to begin to trust you with the more complex and threatening issues of their own life.

Broaden your concept of strengths

Don't assume that clients recognize their strengths. Identifying and focusing on unrecognized abilities and accomplishments facilitates the development of self-efficacy in clients who may be feeling pretty hopeless about their ability to make changes. Exploring the specific steps of a particular accomplishment helps both therapists and clients to identify strategies that clients have successfully used in the past and that could be used now to move toward constructive change, for example: 'Well, you clearly demonstrated a tremendous amount of determination in order to complete your General Education Development examination, given all the obstacles you had to overcome. I'd like to hear more about how you accomplished this.'

Educate clients about what to expect from you

Mandated clients, in particular, may be having to interface with a number of providers and may be confused about the roles of these various people. Clients may attribute authority to you that you do not have. For example, clients may assume that you, as either a therapist or a case manager, have more authority than the referring agency such as the probation or child welfare services. It is important to be clear about the services you provide, what you can and cannot do. Explore the options within the parameters of the services that you can offer and emphasize the client's freedom to make choices among those options, for example: 'I don't have any authority over probation, but I do know that people who come to our programme and work on their issues usually work out their problems with probation.'

Help clients to identify family and friends who have been supportive in the past

Clients who end up in addiction treatment often perceive that they have permanently alienated their entire support system. Encourage exploration of their relationships and the obstacles they perceive to be preventing them from seeking support. For example, the client's own pride and belief that they should now be able to handle their life on their own may prevent them from reaching out to potentially supportive people, or they may feel that they have burned all their bridges behind them due to the choices they have made and the lifestyle they have maintained. The therapist can offer realistic encouragement, for example: 'You're saying that your sister has been very supportive in the past, but after the last argument you had with her you don't think you could ask her to help you out again. My experience in working with people tells me that most people are more likely to help someone who is trying to help themselves. Maybe you can focus on working on your own issues first and then reach out to your sister again.' Or perhaps: 'You mentioned that the best memories of your childhood were summers that you spent with your grandfather. Tell me more about your grandfather.'

Recognize the difference between rescuing/enabling and empowering

This concept may be particularly challenging for beginning providers. Case managers, for example, in their eagerness to assist clients in need, may optimistically load the client with a number of services for material goods as well as referrals for other services such as counselling and legal aid; they are then surprised and frustrated when clients either access only the services providing material goods or none of the services or referrals offered. The metaphor comes to mind of loading a rescue utility vehicle with goods and services: everything

on board, the case manager in the driver's seat, but the client left standing on the side of the road as the case manager drives away in the vehicle.

Beginning therapists may feel impelled to offer premature and unsolicited advice when faced with the many complex issues presented by clients with addictions. Alternatively, they may develop (in a rather directive and pragmatic manner) an overly ambitious treatment plan, and then experience surprise and frustration when clients who appeared to accept the advice and/or to agree with the treatment plan do not follow through on any of the agreed action steps – or very likely do not even show up for the next session.

Slow down the process

In order to empower clients toward more effective goal-setting, the therapist needs to slow down the process and employ the basic strategies of motivational interviewing (that is, reflective listening, using open questions, affirming, summarizing and evoking self-motivational statements) in order to establish a collaborative set with clients. Each goal and each action step needs to be patiently and collaboratively developed between clients and therapists. When the therapy process seems to be stuck or there is some type of impasse, the tendency for most therapists is to push harder to move the process along. However, slowing down the process at that point in time maximizes the possibility of therapeutic change.

Explore options

Emphasize that clients do have choices, and collaboratively identify the menu of options that exists. Identify obstacles and explore strategies for either removing or working around these obstacles. Finally, collaboratively develop specific goals and action steps with clients.

Next manageable step

Small short-term, well-defined and concrete goals increase the chances of success. Help clients to identify the next manageable step that they can realistically undertake in moving towards a particular goal. Success with this manageable step helps to facilitate the development of the self-efficacy necessary for clients to progress towards significant change.

Table 25.1 compares the person-centred motivational interviewing approach to addiction treatment as articulated in this chapter with more traditional approaches, such as the confrontation of denial approach and the rescuing/enabling approach.

Table 25.1 Comparison of treatment approaches

Rescuing and enabling approach to addiction treatment	Motivational interviewing approach to addiction treatment	Confrontation of denial approach to addiction treatment
Premature advice and friendly persuasion	Recognition of client's stage along the continuum of change 1 Precontemplation 2 Contemplation 3 Preparation 4 Action 5 Maintenance Person-centred motivational interviewing strategies tailored to the client's stage of change	Premature advice and head-on confrontation
Frustration when the client is non-compliant	Increased potential for engaging and empowering the client	Frustration when the client is non-compliant
Dismissal of the client from the programme	Non-compliance is viewed as an indication that the therapist needs to: 1 Change strategies 2 Collaboratively review obstacles 3 Collaboratively re-negotiate goals	Dismissal of the client from the programme

Reflections about motivational interviewing as a person-centred approach

In a recent presentation, Miller and Rollnick (2010b, p. 4) state that it is motivational interviewing when:

- The communication style and spirit involve person-centred, empathic listening (Engage)
- There is a particular identified target for change that is the topic of conversation (Guide)
- The interviewer is evoking the person's own motivations for change (Evoke).

Miller and Rose (2009) state that motivational interviewing has two active components. There is a relational component that is person-centred, focusing on Rogers' core conditions with an emphasis on accurate empathy and the interpersonal spirit of motivational interviewing, which includes collaboration, evocation and autonomy. As noted earlier in this chapter, a number of studies have demonstrated

a significant relationship between therapist empathy and positive treatment outcomes for drinking. The second active component discussed is a technical component that involves the competent person-centred use of motivational interviewing techniques to evoke and reinforce client change talk.

Motivational interviewing is clearly rooted in a Rogerian person-centred tradition with an emphasis on the core conditions of accurate empathy, congruence and unconditional positive regard, and a focus on the therapist–client relationship. However, motivational interviewing is an evolution of Rogers' person-centred approach in that Rogers' conditions are seen as necessary but not sufficient. Arkowitz and Miller (2008, p. 4) state that:

> MI [motivational interviewing] can be thought of as client-centered therapy with a twist. Unlike client-centered therapy, MI has specific goals: to reduce ambivalence about change and to increase intrinsic motivation to change. In this sense, MI is both client-centered and directive. The MI therapist creates an atmosphere in which the client rather than the therapist becomes the main advocate for change as well as the primary agent of change.

It is clear that motivational interviewing departs from traditional client-centred psychotherapy with its requirement for an absolute non-directive approach in attitude and behaviour. Cain (2010) talks about broadening the scope of person-centred therapy where it is recognized that the 'core conditions are not sufficient for some clients and provides clients with viable options that are effective' (p. 66) (see also Chapter 17). Cain elaborates on a more relational person-centred therapy, as opposed to Rogers' more individualistic perspective where a meeting between two separate persons is at the core of therapy. The 'emerging view is that persons exist primarily in relationship to each other, rather than as separate entities' (p. 68). The worth and dignity of each individual continues to be valued in these emerging views, but the individualism has been replaced by idea of persons in relationship. Mearns and Cooper (2005, p. 9) describe a collaborative therapeutic relationship 'in which dialogue and interaction take more center stage: one in which it is the encounter between the therapist and client, rather than the provision of a particular set of conditions for the client'. These more integrative perspectives on person-centred therapy are very consistent with motivational interviewing.

Conclusion

Motivational interviewing is a well-recognized and widely employed evidence-based psychotherapeutic method for the treatment of addictive disorders and a wide variety of other problems. It can stand on its own as a separate treatment or serve as a complement to other treatments for addictions. Motivational interviewing is rooted in Rogers' person-centred therapy and focused on developing a collaborative relationship between therapist and client that manifests the core conditions of accurate empathy, congruence and unconditional positive regard.

In addition, motivational interviewing employs a number of strategies that serve as a way of being or a method of communicating with the client in order to evoke and reinforce change talk that leads to behaviour change. It is quite different from traditional person-centred therapy but falls well within the emerging more integrative person-centred approaches. Finally, motivational interviewing has become the cutting-edge treatment for addictive disorders in the twenty-first century at public social service agencies where many clients present with some type of addictive disorder. This has introduced a new group of therapists throughout the world to person-centred approaches.

Points for reflection

- What are the most significant ways in which motivational interviewing is consistent with traditional person-centred therapy?
- How well does research support the importance of establishing a therapist–client relationship with high levels of the Rogerian conditions of empathy, positive regard and congruence?
- How consistent are the four basic principles of motivational interviewing (that is, express empathy, develop discrepancy, roll with resistance and support self-efficacy) with Rogerian person-centred therapy?
- How well might this approach to therapy work with addictive behaviours such as compulsive gambling, cyberaddiction and sexual addictions?

Key readings

- Cameron, R. (2012). Working with drug and alcohol issues. In J. Tolan & P. Wilkins (Eds.), *Client issues in counselling and psychotherapy* (pp. 115–30). London: Sage.

This text provides a brief introduction to a more classical person-centred approach to drug and alcohol counselling work.

- Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analysis. *Journal of Clinical Psychology*, 65(11), 1232–45.

This article summarizes the research findings on the effectiveness of motivational interviewing for a wide variety of problems.

- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

This is the second edition of the classic work by Miller and Rollnick that describes the foundations of motivational interviewing and its application to a variety of settings.

■ Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, 64(6), 527–37.

This article outlines a theory of how motivational interviewing works. Two specific components are proposed: a relational component focused on empathy, and a technical component focused on evoking and reinforcing client change talk.

■ Moyers, T. B., Miller, W. R., & Rollnick, S. (1998). Motivational Interviewing Professional Training VHS Videotape/DVD Series. Available from the Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico.

This six-part series provides an introduction to motivational interviewing in which 10 different therapists demonstrate the skills of motivational interviewing with 12 clients who present with a variety of problems.

■ www.motivationalinterviewing.org

This website provides a wealth of motivational interviewing resources, including a bibliography of published journal articles, books, and so on, beginning in 1983.

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Note

Dorothy T. Fleck died after a 7-month courageous battle with lung cancer on 3rd October 2012 at age 68. Dorothy and her husband J. Roland Fleck, the co-author of this chapter, had been married for over 48 years. She was a loving wife, mother, grandmother, sister, aunt, colleague and friend. She was a total non-smoker and fought a courageous battle against Stage IV lung cancer with a positive attitude and dignity, and without anger, resentment or fear. Dorothy never lost her beautiful smile and had absolutely no fear of dying. Carl Rogers was extremely influential on Dorothy and she believed in trusting the validity of her own experience, the importance of personal presence and meaningful engagement in all interpersonal relationships. She is dearly missed and will be in the hearts and minds of all who loved her forever.

Part IV

Professional issues

Edited by Maureen O'Hara

Since the first edition of this Handbook, the world of counselling and psychotherapy has changed in some significant ways. Of particular relevance for the person-centred practitioner is the increasing professionalization, standardization and medicalization of the field. One consequence of this is that there has been a growing insistence that treatment be tailored to address specific conditions (diagnoses), and that there be verifiable evidence of successful outcomes for any method (see Chapter 1).

This presents person-centred practitioners with some challenging dilemmas, especially those who work in state- or insurance-funded settings where the expectations for performance originate within a modernist, medical frame. The core commitment of the person-centred approach that each person be met by their therapist with a sense of openness to the unfolding experience that emerges between them is at odds with the view that professionals approach their patients or clients using a predetermined lens prescribed by a diagnosis or treatment plan.

Another development has been the accumulation of further evidence from research supporting the claims that a person-centred process-oriented therapy is as effective as cognitive-behaviourist approaches in bringing about positive change. There is now an increasing use of approaches grounded in person-centred principles applied to broader social concerns.

The authors in this section approach these meta-issues facing professional person-centred practitioners, and students who are preparing to enter the field, in a variety of ways and suggest strategies to meet today's challenge while remaining faithful to the core tenets of the approach. The chapters include vignettes where the theoretical concepts are embodied in concrete clinical examples.

Chapter 26 by Richard Worsley discusses what needs to be done concretely to establish a practice environment that is congruent with person-centred principles of practice. He includes private practice, social agencies and mental health clinics where diagnostic assessment, evidence-based standards and Increased Access to Psychological Therapies expectations require collaboration with colleagues from other disciplines. Issues of contracting, boundaries and the demands on the person-centred practitioner in a medicalized context are discussed, helping new practitioners to set off their career on a sound footing.

Chapter 27 by Ewan Gillon is new to this edition and reflects the changes in the counselling and psychotherapy fields that have occurred since the first edition was published. It describes how the assessment, diagnosis and case formulation that are now the 'standard of care' in many mental health settings can be understood and successfully integrated into person-centred practice.

In Chapter 28, Gillian Proctor and Suzanne Keys contrast an ethic of justice with an ethic of relational trust and, through exploring the nature of an explicitly person-centred ethics, emphasize the essential relational nature of person-centred professional ethics. Vignettes are offered to pose situations where different ethical traditions might indicate more than one direction for the practitioner.

Chapter 29 written by Colin Lago, joined in this edition by Japanese colleague Tatsuya Hirai, addresses the challenges of diversity with respect to culture, class, sexual orientation and gender for the person-centred practitioner, and provides guidance on the basic attitudes and approaches that support sensitive multicultural practice.

In Chapter 30, Elke Lambers addresses the importance of the supervisory process as an essential element of ethical practice and for ongoing growth in the capacity of the person-centred practitioner for congruent relational depth. She reviews person-centred writing on supervision and highlights how person-centred supervision differs from more generic approaches to supervision.

Robert Elliott's chapter considers the increasingly important role of research into practice outcomes in the mental health field. Considering person-centred experiential research from both positivist and post-positivist frameworks, he points to a path balancing the needs of a positivist mainstream and the growing edge of outcomes research in a chapter that will support those who work in environments that privilege outcomes research.

The next chapter in the section considers how person-centred principles can be applied to the looming issues facing humanity at large. Maureen O'Hara traces Rogers' commitment to social and organizational issues and discusses person-centred practice as a resource for those engaged in social transformation.

The final chapter of the book, by Roelf J. Takens, provides an updated, detailed and comprehensive review of resources available to the experienced practitioner and student of person-centred psychotherapy and counselling.

26

Setting up practice and the therapeutic framework

RICHARD WORSLEY

This chapter discusses:

- Practical issues in setting up practice
- The concept of freedom to practise, which is at the heart of person-centred therapy
- Pressures that can be felt in the early days of practice
- The needs of the beginning therapist, approached in such a way that clients' needs are also met
- Beginnings of therapy, and in particular client assessment as adequately containing for the client
- The ability of the fearful beginner to provide sound boundaries and sufficient intimacy for the client
- The tension that can exist between the beginning therapist's congruence and her acceptance of the client

> There can be no doubt that every therapist, even when he has resolved many of his own difficulties in a therapeutic relationship, still has troubling conflicts, tendencies to project, or unrealistic attitudes on certain matters. (Rogers, 1951, p. 42)

Entering therapeutic practice

As early as 1951 (as exemplified by the quotation above), Carl Rogers was aware that good therapy depends crucially upon the personal development of the therapist. For

mature therapists, the tasks of personal and professional development are important enough, but for the beginning therapist the task is indeed challenging. At the very time when shifts within the personality are taking place through both training and client contact, it is necessary to find a personal stability upon which the therapeutic framework can be built together with the client.

The chapter is written mainly for the new therapist but is also relevant to her trainers, supervisors and more experienced colleagues. The more experienced therapist may feel exempt from these dynamics. Is this really the case? When the service in which I work is under the pressure of a long waiting list, I can feel myself circling through some of this material once more. The purpose of the chapter is to bring to light some of the processes that mark out personal development during the early days of practice and that are specific to beginning work as a therapist. The new therapist needs to become consciously aware of both the pressures inherent to her situation and her own responses to them. She strives to be a reflective practitioner, who can engage openly and honestly both within herself and with others to integrate into her attitudes and her way of being her personal reactions to her meeting with clients (Schön, 1987).

Until the beginning of client work, learning about counselling and psychotherapy will have been stretching enough. We face the ghosts of earlier learning processes; we struggle to relate theory to our own growth and experiencing; we encounter the growth and the pain of our fellow students in group work and in practicum. Yet, until the first client, all is preliminary. On many courses, finding a practice opportunity proves difficult, frustrating, a source of fear of failure. Most students of therapy will have to struggle against internal constrictions in order to find freedom to practise.

The focus of this chapter is the need to deal at a conscious level with unfamiliar pressures from within and from without. The therapeutic framework requires competence in a number of practical skills. I make brief reference to these in the next section. However, these can be a distraction from the development of inner stability, and in any case form the core of professional development modules on diploma and degree courses. At the heart of moving from the role of novice to that of sound practitioner is the capacity of the therapist to be free and available to provide psychological containment for the client.

Practical considerations

Good brief guidelines for beginning practice already exist (Dryden, Horton, & Mearns, 1995; Mearns, 1997); these do not need to be repeated here. Mearns (1997, pp. 69–70), summarizing Dryden et al. (1995), notes the following as needing understanding in particular:

- selecting and contracting with a supervisor;
- the practical and ethical issues of recording counselling sessions;

- personal safety and security for the counsellor;
- writing case notes;
- record-keeping, confidentiality and the law;
- writing letters to clients;
- developing a resource network;
- making referrals;
- introduction to the relevant professional code of ethics;
- ethical decision-making and problem-solving;
- advertising;
- dealing with client fees;
- insurance;
- setting up and working with an organization;
- monitoring and evaluating one's competence;
- evaluation of client work;
- using research reports;
- issues of accreditation or registration;
- understanding national and international issues in therapy;
- the nature and purpose of supervision;
- stress and burn-out;
- professional development and further training.

All of these matter, but all depend upon the new therapist finding reflective stability.

Freedom to practise

Carl Rogers' theory of therapy (1957) and of human personality (1959) state that as people experience acceptance, empathy and congruence, they will be able to take back into themselves the responsibility for evaluating their life experience. This change involves a clearer, less conditioned and less conflicted relationship between their self-concept and their experiencing of the world around them. This is not just true for the client seeking reduced distress: it is basic to all human growth, and hence to activities as diverse as counsellor supervision (Tudor & Worrall, 2004, 2007) and schooling (Rogers, 1969). This freedom is a freedom from others' judgement. It is a freedom into fluency of self-experience. Hence for therapists, it is a freedom to practise.

The image I have developed for the freedom to practise is that of a raised platform on which the therapist dances with the client. Only a small portion of the surface of the platform is near the edge. We need to know where the edge is, and what shape it is. If we do not, one or both individuals may fall off. However, if we are dominated by fear of the edge, we will never dance freely. Let us then consider the edginess of early practice, so that, in freer self-awareness, the dance of psychotherapy may commence.

The early pressures

There is a fundamental paradox of beginning practice. All practitioners are responsible for acting within their competence. Yet the trainee bears this responsibility when their competence might be most fragile and when their ability to assess both their own abilities and their clients' needs is immature. Beginning practice brings external pressures that in turn interact with the trainee's internal dynamics. This complex interaction is difficult for even the well-supported new therapist to manage. Reflective practice is at a premium.

Trainees are themselves in process of growth – some with vigor and freedom, and others with fear and hesitancy. My experience as a teacher was that a group of nurses could learn about conditions of worth in half an hour, so long as the idea did not occur to them that Rogers' understanding of the personality might disrupt their own self-concept. In contrast, professional-level therapy students have to wrestle with their own conditions of worth and incongruence. This is painful and disruptive. The fear of failure, and other manifestations of conditionality, both conscious and unconscious, is often prevalent at exactly the time that the first client enters the scene.

Courses and tutors can make matters worse. In the first term of a professional training course, I became aware of a suspicion that the tutors could not do what they were expecting others to do (a common enough group defence against learning.) However, one session of demonstration later led to the so-called halo effect – the idealization of the tutors as a defence against the anxiety of learning. Tutors, it turns out, are not totally incompetent. In fact, they are not bad. The trainees are now intimidated and thrust down into their own sense of inadequacy. Occasionally, trainers can aggravate the situation. Recent supervision debate has identified a tendency for some tutors who are rigid or dogmatic in the face of their own underlying fears to produce stress, suspicion and mistrust in their students (Tudor & Worrall, 2004; Box 26.1). In a number of ways, the processes of training, competent and incompetent alike, can add to trainees' burdens.

Box 26.1

Incompetent supervision

One or two trainees in any year will have a poor experience of supervision. I recall in particular watching one young woman sculpt her supervisory relationship. She placed her supervisor standing on a table behind her, facing away. The client was curled up, fetus-like, in a ball at her feet. I terminated the placement, but the harm to her confidence was already done.

It felt to me as if the fetus-figure was not only the client, but also part of the counsellor. She had experienced herself as besieged and ignored by a person who should have been trustworthy. It is likely that this experience echoed with other experiences of being ignored or perhaps with desertion in her life.

The beginning therapist finds herself in a network of trainers, supervisors, agency managers and clients. At a point of vulnerability, it is crucial for her to distinguish accurately her internal dynamics from genuinely difficult, even aggressive and attacking external dynamics. Fear, concealment and some paranoiac feelings are to be expected. Supervisors and trainers have to strive hard to accord the trainee the freedom to recognize and process the so-called negative. This general dynamic is rooted in specific issues.

Facing the issues

The good-enough client – or will my needs be met?

Therapists provide boundaries or containment for the client, as well as accompanying the client on their journey. To hark back to my metaphor of dance above, therapists delineate the ring, the sacred space of meeting, and then move with the client within it. Both the containment and the dance constitute the necessary safety – good-enough safety – to facilitate change. In order to provide containment, therapists must be congruent about their own needs.

The beginning therapist can be open both to the fear that her needs will not be met and to the fear of acknowledging this hunger. Peggy Natiello observes: 'Collaborative systems depend on open, full participation of each member. Persons who hold themselves back out of fear of taking over often inhibit the success of the experience' (2001, p. 70).

For example, the new counsellor needs practice hours to complete the qualification. It is so easy to feel that the client who fails to attend the session is letting her down. It becomes a source of irritation instead of an aspect of the therapeutic process. Yet the counsellor feels she owes the client unconditional, positive regard. The irritation cannot be admitted. The relationship can slip into incongruence. Concealed anger and frustration with the client produce in the therapist a rigid and unresponsive, self-judging and fearful presence. Acceptant self-awareness can only be achieved through a recognition of both this process and the legitimacy of the needs of the new therapist, although not at the client's cost.

Again, some beginning therapists 'require' their clients to express feelings. This satisfies their need to be empathic. Sometimes this comes from within, sometimes from the trainer who exalts empathy to the be-all and end-all of therapy. As a supervisor, I have, from time to time, heard new therapists disapproving of clients who retell endlessly their story, devoid of overt emotion – as if this were somehow invalid. The fears and requirements of the new therapist distort her listening to the client and so prevent the dance of psychotherapy.

Containing – beginnings and endings

When the first client walks into the room, it is a moot point who is the more anxious – client or therapist. Even as an experienced therapist, I still feel nervous

at times. I meet the fantasy of my limitations and feel a drive to 'do well'. Meanwhile, clients may be very unsure about what counselling and psychotherapy are, what they will be expected to do and whether therapy will not just be another failure in their lives. The underlying anxiety of the therapist can manifest in a number of ways: Will the client talk? Will I be liked? Will I 'get to' what the client feels? There is a paradox in play here. The anxiety is understandable enough. Yet the job is not to do well, not even to 'do it right'.

There are indeed things to think through about contracting:

- Do the clients understand the limits of confidentiality?
- Do the clients have some sense that they will not be 'done to' as they might be by, for example, their doctor?
- Do the clients feel safe enough?
- What are the time limits if any?
- When will the work be reviewed?

The beginning and the ending are present together from the word go. All these practical things matter. However, the paradox is that they must not matter too much. Dave Mearns and Brian Thorne (2000) describe their own contracting style as 'sloppy'! This is not irresponsible but a question of good balance. I take it from some personal knowledge of the undoubted competence of both Mearns and Thorne that 'sloppy' here encodes a potential criticism they fear from the up-tight, but also a willed decision in the face of this to relax and welcome the client. 'Sloppy' signals exactly that which is precise and balanced: the client can explore in contracting whatever safety issues she feels, while the counsellor can take the risk of not being 'on guard' against imagined hazards. It is, however, easier for either Mearns or Thorne than for the beginning counsellor to provide this level of containment.

The idea of containment is often associated with psychodynamic thinking. Yet it is and has been at the heart of person-centred practice from the beginning. Patrick Casement (1985, p. 133) describes the client's needs thus:

> In more human terms, what is needed is a form of holding, such as a mother gives to her distressed child. … And it can be crucial for a patient to be thus held in order to recover, or to discover maybe for the first time, a capacity for managing life and life's difficulties without continued avoidance and suppression.

Rogers (1951) had described the containing process in terms of the therapist's addressing the client's fear and consequent dependency, through providing safety and openness sufficient to facilitate the exploration of painful or denied material (see Chapter 8).

Clients are often afraid of what they feel, or of the sense that this may spill out everywhere, or even of the belief that they ought to spill it out straight away. A warm but calm contracting, brief maybe, relaxed, checking for informed consent with respect, can help the client experience the possibility from the very beginning that the process of therapy is not a spilling out but a gentle receiving.

Assessing and relating

By now, the reader may have a sense that beginning work as a therapist is about facing one's own self through a number of paradoxes. Some of these are about the anxiety inherent in being inexperienced. Others are inherent in the person-centred paradigm itself. Beginning work with any given client is first and foremost to enter into relating. Yet therapists are ethically bound to work within their competence and to be able to monitor and demonstrate this. The beginning therapist in any approach is most likely to need to consider referring on, on the grounds of competence, and yet will be underexperienced in assessing competence. Indeed, it is understandable that beginning practitioners often fail to appreciate the power of the person-centred approach across a wide range of presenting mental health issues (Joseph & Worsley, 2005). It is tempting to say: 'I do not know about trauma' or 'I have never worked with people who are anorexic' (Worsley, 2005).

We are obliged to assess our clients (see Chapter 27), yet we work within an approach that has been thought to scorn assessment as being 'too expert'. For those who espouse the role of expert, assessment can be a complex and time-consuming technical exercise (Palmer & McMahon, 1997). Some within the person-centred and experiential field who incline to a more experiential or focusing orientation will also rely upon psychodiagnosis (see, for example, Greenberg, Rice, & Elliott, 1993; Purton, 2004). Yet the classical, client-centred practitioner, along with others, will be chary at the notion of diagnosis.

In this, there is a complex debate to be had (Cain, 2002; Patterson & Watkins, 2005; Purton, 2004; Wilkins, 2009). Tony Merry (1999, p. 65) has set out crisply and accessibly the main objections to diagnosis:

- Diagnostic labels are often meaningless and poorly defined.
- Labels can become self-fulfilling prophecies.
- Diagnosis leads to the stereotyping of clients.
- It focuses on history rather than current states and attitudes.
- A preoccupation with pathology can lead a therapist to underestimate a client's strengths.
- Diagnostic categories tend to be biased according to gender and race (Lago & Smith, 2010).
- Diagnosis puts the therapist into an expert role, a role for which she is likely to have received inadequate training.
- Diagnostic labels can be beguilingly scientistic, and can skew the therapeutic attitude.

Yet to reject the idea of assessment completely is both a misunderstanding and an ethically dangerous one at that. Paul Wilkins (2005) and Wilkins and Gill (2003) have explored what is meant by person-centred assessment. What is to be avoided is recourse to the medical model to label and hence, in mental health contexts, dehumanize the client (Sanders, 2005). It is not just an ethical issue but a technical one

too. Each person is unique. They are unique in their processing, their ways of functioning and their life patterns. It is only when I let go of mental health stereotypes that I can see the true potential in each client for growth. However, assessment need not be about this classificatory nonsense.

Assessment happens *in relating itself*. It has at its heart the question: Can this person and I enter into a therapeutic relationship? Is there psychological contact between us? It is both useful and reassuring to be able to recognize something of those parts of client process that are contact-impaired (Prouty, Van Werde, & Pörtner, 2002). Yet difficult clients must be taken to supervision. The ability to work with challenging client groups comes with experience.

Assessment is, then, an ongoing, therapy-long process. The skill is to listen to the client from two places. With most of my attention I strive to accompany the client, but with a small part of my attention I seek to know what might get in the way of this contact. The beginning therapist is often working with senior colleagues whose model involves thorough, formal and sometimes paper-bound assessments in agencies that are increasingly risk-averse. It takes personal stability to maintain a practical commitment to person-centred assessment.

Yet person-centred therapists do not work in isolation. We need to be able to communicate with other members of our profession. These may be therapists following other modalities, psychiatrists, clinical psychologists or medical practitioners. The language of assessment must then be a shared language across disciplines. This is a huge cultural challenge for the beginning practitioner. To use the language of psychodiagnosis can feel like a sell-out (and, indeed, it can be one). Lisbeth Sommerbeck (2005) makes a strong and practical case for working congruently but positively in psychiatric settings. Generic textbooks on counselling and psychotherapy offer useful perspectives on what might be expected of us as professionals (Bager-Charleson & van Rijn, 2011; Lewis, 2010). Indeed, the first of these texts is required reading for those who wish to demonstrate their competence as practitioners of the Improving Access to Psychological Therapies (IAPT) programme Counselling for Depression (Hill, 2011) (see below).

External pressures and contexts – to promote the approach, first engage

The whole question of assessment is, however, just one example of a broader concern that faces person-centred therapists in practice in the UK today (and there will no doubt be parallels in other parts of the world). The person-centred approach has, over the past four decades, become more and more diverse (Sanders, 2003). This diversity has been about the relationship between the purists and the experientials, between those who adhere to what might be perceived as Rogerian, and those who integrate insights from focusing and from experience-focused therapy, among other traditions. This produces conflict within some therapists. We need to decide where we stand and how we accommodate this diversity emotionally.

This diversity is only one source of challenge. It is internal to the thought of the approach. Other challenges come from the contexts in which counsellors work. What follows can only be a very brief summary of the key issues in play today.

In the UK, the government programme IAPT has rationalized the provision of therapy in the National Health Service. IAPT is evidence-based. It has in its initial phase privileged cognitive-behavioural therapy, because this therapy was better at evidencing its effectiveness. The humanistic therapies have begun to assert their own evidence base. Thus Counselling for Depression (Hill, 2011) is now a recognized way of working with mild to moderate depression. However, person-centred practitioners have to retrain – a brief, 5-week, training – and this training is linked to a list of competences. Competences tend to be surface, and rather contrary to the intuitive and humane approach of many practitioners. The question is posed: can we live with evidence-based practice and competences in order to provide the benefits of our approach? We need to, but there is for some an emotional cost of seeming to conform to some unsympathetic, external ways of thinking about therapy.

In the same way, person-centred therapists have learned that the autonomy and natural wisdom of the client means that clients need the space to decide how long therapy should continue. This feels like a rational and an emotional investment. Yet many jobs in counselling are based on short-term work. Does this have integrity? My own work in a university counselling service moved about 5 years ago from unrestricted use of time to a clinical norm of five or six sessions. Some higher education services enforce this limit; my own does not, but a waiting list approaching 200 individuals does clarify the mind. My own experience is that some creative thinking and supervision makes the model of short-term work surprisingly enjoyable and viable. At first, though, the transition was hugely stressful and unwelcome: it took me 3 years to adjust and I am still learning. The literature concerning short-term work is now growing (Tudor, 2008; Tudor & Worrall, 2007).

In order to have work, to have funding and thus to promote the person-centred approach, practitioners are having to build bridges, to adjust to practices and ways of thinking that have in the past seemed alien. The beginning practitioner must exhibit this new-found openness. And this can have its emotional costs.

There are a number of psychological instruments that counsellors can be required to use. Perhaps the Clinical Outcomes in Routine Evaluation (CORE) instruments are the best known. Person-centred therapists are moving swiftly from being ill at ease with these to seeing them as crucial to the development of their own evidence base. Bill Stiles has done excellent work on CORE (Cooper, 2008) and has contributed to nine different pieces of research in Mick Cooper's overview. Robert Elliott and Beth Freire (2008) performed a valuable meta-analysis of the evidence base for person-centred therapy, part-funded by the British Association for the Person-Centred Approach. In short, the research activity, in particular that at Strathclyde University, witnesses not just to the effectiveness of person-centred therapy, but also to the need to assert its evidence base (Cooper, 2011). Person-centred practitioners need to become familiar with such instruments as CORE

because, like it or not, we live in a world that can make demands upon us if we wish to be funded or employed.

It is worth noting briefly that new-found alliances sometimes produce remarkable synergy. The critical psychology and psychiatry movement has generated a critique of diagnosis that allows us to engage intelligently and with integrity with the psychiatric establishment (Bentall, 2004). Similarly, the unfamiliar territory of positive psychology is a good ally. In the USA, Martin Seligman had proposed that psychology should refocus on the constituents of human growth rather than human pathology. In the UK, Stephen Joseph has used this insight to build profound links between the psychology of trauma and person-centred therapy (Joseph & Worsley, 2005; Levitt, 2008; Worsley & Joseph, 2007). Stephen Joseph's work on trauma is a vital metaphor for the state of person-centred therapy today: it is painful to grow but there are no other options but growth.

With this in mind, we return to the presence of the therapist with the client.

Intimacy and boundaries – or why what *I* feel is not open to judgement either

It is the quality of our presence that matters. There is a growing amount of research into what constitutes good therapeutic presence (Geller & Greenberg, 2002; see Chapter 14). Brian Thorne (2004) has explored in some depth the notion that tenderness is at the heart of person-centred therapy. He does not put it forward as what one might call a fourth therapeutic condition, but rather as a way of encapsulating the whole enterprise of person-centred therapy. It is Thorne's experience that tenderness given and received liberates us into a wholeness in which the other person is no longer the feared Other but a welcome and beloved companion.

Jan Hawkins (2002b) has argued fluently from her experience of working with those who have been sexually abused that the client's remaining with the distress feels paradoxically safer than moving into new and therefore feared territory. Tenderness, intimacy, is an essential quality in that it provides just enough safety for the frightened client. Similarly, clients whose fear leads them into challenging behaviour need the safety of intimacy before they can find a more functional pattern of relating to others (Hawkins, 2002a).

Person-centred therapists are called to be available for intimacy with others. (Those of us who are shy can find this a strain at times; and sometimes it is easier to be intimate with clients than the rest of humanity.) Intimacy requires that boundaries be thoroughly in place. It is not, I think, enough, to know that it is unethical to have sex with a client. Do you know why *you* would not have sex with a client? How do you relate to that part of you that keeps that boundary in place? If you see it as a necessary but tedious old puritan, how safe are you? How do you relate to that part of you that wants to have sex with a client? Do you deny it? Are you, or do you pretend to be, appalled by it? Perhaps it too needs your love and acceptance. It can be telling you something useful. If we aim at intimacy, it is not enough to know what is ethical.

Intimacy is that condition in which, while professional boundaries remain in place, tenderness, a sense of affection and even love (*agape*) can be felt and appropriately expressed. Intimacy subsists in a respect for the hiddenness of others within themselves, and hence for the deep preciousness of their self-disclosure. Intimacy can encompass feelings and even fantasies of friendship and of the erotic, but always directed to the wholeness of the other. It is a powerful affirmation of the ability of the other person to enter into deep relating, into what Buber (1958) has termed the I–Thou relationship (Box 26.2).

Box 26.2

Ending with Alex

In a short-term setting, I had worked for nearly 2 years with Alex. She had presented as a disturbed young lady who was deeply anorexic. By the end of the work, we had lived through her anger, in particular with her mother, her refusal of food, then her desire to eat, and lastly her deep fear that she could no longer ingest food. At times, I had felt saturated with her tears. Yet I had grown very fond of her, and indeed still miss her. She was a student of French literature. We had explored – as best I could – which authors made her feel alive, as if life was to be lived. I had also identified that we shared a passion for Douglas Adams' *Hitchhiker's Guide to the Galaxy*. And between bouts of anger, we laughed a lot.

When the ending came, each of us said we felt apprehensive. She was flying solo. I was the redundant co-pilot. We had to be honest. Neither of us knew if she would make it. I needed to tell her how close I felt to her. I thought she was a lovely person. I would miss her. I said that I had learned a lot from her on the way through a long journey shared. I told her that she had not always been easy. I sometimes felt compassion for her mother, who made her so rageful. I said I was often frustrated by her determination to swamp the room with her interest in food. But finally I pointed out that we had indeed met on 42 occasions. We laughed. I offered her my hand to say farewell. She smiled, told me not to be silly and hugged me. It was indeed a parting gift!

All those who are aficionados of Douglas Adams will know that 42 is the answer to the meaning of life, the universe and everything. It was not merely that, in ending, I wanted to let Alex know my affection for her, real though it was and is. The intimacy was a combination of attention to the journey and my part in it as well as hers, together with a sense that she and I had made contact at a deep level, at a spiritual level I would say.

In order to be intimate with another person, I must know and accept all that I feel. Beginning therapists are sometimes afraid of the intensity of positive, and in

particular erotic, feelings. They are also afraid of strong, negative feelings, mistaking them for a lack of unconditional positive regard. I do not want to be misheard here. It is perhaps rarely appropriate to disclose strong feelings without careful reflection. If I am going to work with strong feelings towards a client, I would normally opt to work them through in supervision, and above all ask the perplexing question: why would my feelings be therapeutic for the client?

So why do strong feelings matter? I fancy my client. I can't stand her. I fear her. I feel huge affection for her. Beginning supervisees often betray a sense of guilt at such feelings even when they get around to expressing them. Yet *my* feelings too are not open to judgement. They are valid because they exist. They may be 'my stuff' or they may be of greater significance.

Strong, personal feelings of liking or disliking can, I believe, function in two separate ways. They can be informative. I recall a client whom I found very attractive – increasingly so, in fact. I noted this. My supervisor would not let me escape it, but nor was I to blame for it. After a number of sessions, my client recognized in herself that she used her sexuality habitually – and usually outside her own awareness – as a bargaining power in order to cover up her radical lack of self-esteem (Cashdan, 1988). My erotic feelings – at least in part – were very informative. They mirrored how my client normally influenced men, a potentially destructive pattern.

Yet this view of my feelings as useful has limits. It can feel to me rather instrumental. My feelings about the client are not there to inform me, but to be part of me as I accompany another human being on her journey. My feelings are me. All of my feelings are me. I bring to any relationship even – perhaps especially – those feelings which are so readily seen as politically incorrect. I need to know and accept, albeit critically, all that I feel. Encounter that is at the heart of therapy involves two people learning to be willing to bring to each other their whole selves as fully as is warranted (Schmid, 1998).

The question of facing all that I feel is just one case of the need for therapists to face what they meet in their clients. Person-centred therapy has an existential dimension to it (Cooper, 2003; Worsley, 2009). We meet all that makes up human existence. In others, we will meet our sexuality, our mortality, our guilt, our shame, our joy – and so the list could go on. Unless we have acceptingly befriended our fears and hopes in our own existing, we will simply fail to hear as fully as we might our clients' experiencing.

Idealizing the client – or how to misunderstand the core conditions

The new practitioner is often prone to defend against the process of supervision. If the supervisor notes a feeling in the counsellor that the latter cannot accept in herself, the observation will be experienced as judgement, condemnation. (And indeed some supervisors recycle their own insecurity as judgementalism.) Therapeutic practice often begins before the counsellor experiences a high level of

self-acceptance through the personal development elements of training. Thus, as noted above, the new practitioner will often condemn or reject her own feelings towards the client.

In parallel to this, the client is often idealized. It is thought that empathy must involve not only a warm accompanying, but also a rejection of all negative feelings towards the client. Unconditional positive regard then becomes a requirement in order to disregard negative feelings. This is clearly a misunderstanding of the core conditions of therapy. Campbell Purton (1998) has argued cogently that all attempts to offer unconditional acceptance will flounder upon either the client's shortcomings or the counsellor's. True acceptance is not, Purton claims, an empirical opinion about the client, but rather is a stance in principle. It is to believe from the depths of one's being that humans deserve acceptance and love without reservation. For Purton, this is rooted in Buddhist philosophy, while for me it is an aspect of Christian faith. Each person-centred practitioner needs to locate the philosophical roots of their acceptance of others.

These roots should not be idealistic, in the sense that they function as just another 'ought'. In fact, they should call the practitioner away from an idealization of the client. When acceptance is absolute, transcendental, then our feelings, however messy, can coexist with our acceptance (see Chapter 12).

I remember all too easily a client with whom I worked some 8 years ago. He was objectionable, not because he was immoral or cruel, not because he was attacking or aggressive, but because he whined incessantly with self-pity. I did not like him. But then neither his wife nor his mother liked him. I pitied him. My desire to be a 'good' counsellor stopped me from being congruent. I was unable to express my dislike, for fear of being judgemental. In this, I robbed him of the one thing that I could have given him: the knowledge that others' reactions to him were rooted in his way of presenting himself and his needs. His needs were legitimate enough. He needed to discover that he had choice in how to present them.

When the feelings that might get in the way of empathy and acceptance are allowed into full awareness, congruence flourishes. In the end, I will be able to work through in supervision how and in what way – if at all – my negative feelings can appear in the therapy room in a way that is truly therapeutic. The offering of the core conditions should not lead to an idealization of the client or the relationship but should open up the fact that really good relationships can indeed be quite messy (see Chapter 17.)

Conclusion

Each person begins work as a therapist with unique gifts and equally unique and valid personal needs. What binds each new practitioner with every other one is the need to do therapy with a reflective insight that links practice with personal awareness. Whether we feel exultant or fearful of our task, we can fool no one more treacherously than fooling ourselves.

Points for reflection

- How do I balance my genuine needs with those of my client in a therapeutic relationship?
- How do I assess my clients? Does this in any way limit my seeing of them as unique individuals?
- How do I use any negative feelings I have for the client? What is therapeutic for the client? Do I avoid negative feelings?
- What are my principled grounds for accepting other people?
- What view do I take of diagnosis? How do I communicate with other professionals?

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27
Assessment and formulation

EWAN GILLON

This chapter discusses:

- The role of assessment and case formulation in the mental health field
- The nature of assessment and case formulation processes as employed within more 'medicalized' approaches of psychological therapy
- A person-centred critique of assessment and case formulation
- How assessment and case formulation processes may be conceptualized from a person-centred perspective
- The ways in which a case formulation may be integrated within a person-centred approach to working with clients

What is assessment, diagnosis and case formulation?

The processes of assessment, diagnosis and case formulation present some very significant challenges to the person-centred practitioner. These are fundamental to the mental health field, a context presently dominated by 'medicalized' perspectives that view distress in terms of specific 'disorders' that may be distinguished and classified (for example, via classification schemes such as the ICD10 or DSM IV).

An 'assessment' is the process through which the specific mental health disorder(s) are identified on the basis of signs (observations made by the clinician) and symptoms (self-reports of particular manifestations or experiences by the client). In most medical settings, the assessment process is conducted using a range of methods that can include consultation of medical notes or referral letters, psychometric measures and face-to-face meetings. On the basis of the information gathered during the assessment, a 'diagnosis' is made (that is, which disorders are present) and treatment

planned accordingly. In medical settings, treatment is normally based on protocols from the evidence base with regards to that particular disorder, which can include pharmacological, physiological, systemic, social and psychological interventions.

For those psychological practitioners (for example, counsellors, psychotherapists, psychologists and so on) working within a medicalized framework, a diagnosis is necessary for treatment planning (and funding), and thus assessment procedures often assume a similar diagnostic shape. However, the assessment process is also seen as offering another function – namely the opportunity to develop a 'case formulation' of the client and his or her difficulties. In recent years, an increasing amount of emphasis has been placed on the case formulation in the psychological domain. For some, it is this that is now seen as the distinguishing feature of a psychological approach to mental health distress, differentiating it from the more diagnostic approach of psychiatry.

In simple terms, a case formulation provides a detailed understanding of a client's problems, most commonly in terms of their nature and impact, their predisposing, precipitating and perpetuating factors and the relationship between these, and the implications of these data for the establishment and setting of appropriate treatment goals and processes (Sim, Gwee, & Bateman, 2005). Although specific definitions of case formulation differ, what they have in common is their function to make sense of a client's distress by using psychological theory (Johnstone & Dallos, 2006), thus providing a conceptually and evidence-based framework for therapeutic intervention. The case formulation may relate to, or encompass, a diagnosis, but the two processes are not synonymous and thus each can occur – albeit unusually – without reference to the other.

All psychological theories are social constructions based upon a specific view of the world. Case formulations are thus concepts derived from a particular set of assumptions, normally those supporting the model of psychological therapy adhered to by the practitioner. Predominant in the mental health field at present is the cognitive-behavioural model, which emphasizes the centrality of maladaptive thinking and associated behavioural patterns in problematic emotional experiencing (that is, psychological distress). This model provides a basis for case formulation by emphasizing the systematic and situational interaction of maladaptive beliefs and behaviours in the form of the 'five Ps' (Dudley & Kuyken, 2006):

- presenting issues (the nature of client's problems linked to thoughts, behaviours and beliefs);
- precipitating factors (the factors that triggered the current episode of distress);
- perpetuating factors (internal and external factors that maintain the distress);
- predisposing factors (historical aspects that increased the client's vulnerability to distress);
- protective factors (aspects of the client that enhance resilience).

A similarly theoretically informed approach to case formulation can be seen within other domains of psychology, such as the psychodynamic approach (Johnstone & Dallos, 2006).

In offering a description of, and often an explanation for, a client's distress, the case formulation is used to plan therapeutic 'treatment' in the context of theory, the 'evidence-base' and the available resources. For Sim et al. (2005), 'an adequate formulation is a precious blueprint guiding therapy, including the setting of appropriate goals and choice of intervention point, modality and strategy' (p. 291). Hence the case formulation is an inherent part of clinical practice, informing both the choice and focus of therapeutic intervention at the outset, as well as on an ongoing basis. The case formulation is not a 'fixed' entity, but is under constant revision and elaboration as therapy progresses (Johnstone & Dallos, 2006). However, once developed, it inevitably forms a 'frame' from which the therapist may find it hard to deviate.

Sometimes, as part of the therapy, a case formulation, or pertinent aspects of it, are shared with the client via transference 'interpretations' in the psychodynamic model, or through explicit discussion with the client, as in cognitive-behavioural therapy. For some clients, understanding the distress being encountered via a case formulation of these is of great help, As P. S. (2006), a client engaging in cognitive-behavioural therapy, states: 'The formulation made the incomprehensible accessible. It explained and imparted insight. I understood myself. The formulation had the authority to disclose to me that which I otherwise have been reluctant to accept' (p.13).

Although it is commonly acknowledged that understanding the client's 'own formulation' (see, for example, Sim et al., 2005) is of relevance in supporting the progress of therapy, this is seen as of lesser value within psychological models taking a case formulation approach. A case formulation is inherently 'expert' oriented, linking as it does psychological theory to practice. In this sense, it presents some significant challenges to those working from a person-centred perspective.

Assessment, diagnosis and case formulation: a person-centred critique

In contrast to 'expert-oriented' approaches, the person-centred approach sees clients' experiences and perceptions as themselves of primary importance at all stages of contact between client and practitioner. As Rogers (1951, p. 22) suggests, 'In a very meaningful way therapy is diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician.' Person-centred practitioners thus strongly object to any processes of assessment, diagnosis and case formulation that prioritize the expertise and interpretation of the clinician over the experiences and perceptions of the client. If, as Rogers (1961) suggests, it is the client who knows 'what hurts', then it is the client who should be trusted to determine the content and focus of the therapy, not the therapist. Relying on definitions of specific 'disorders' and/or expert 'case formulations' of clients' difficulties is seen as a move away from the clients' own personal experiences, rather than towards them.

The emphasis within person-centred therapy on the *emergent* process of change also conflicts profoundly with approaches attempting to diagnose or substantially

plan treatment at the outset via a case formulation. Pre-emptive and expert-driven assessment, diagnosis or case formulation activities can fail to account for the potential ways in which an individual, and his or her needs, will evolve during any therapeutic process on an ongoing basis, as organismic experiencing is contacted and integrated within the self. Furthermore, they also create a power imbalance that may work against a client developing an internal locus of evaluation. In this regard, they may be seen as more harmful than helpful (Mearns & Thorne, 2000).

A further challenge to the process of assessment and case formulation procedures links to the deficiency-based model from which they derive. Such procedures focus on the 'problem' and not the 'person', and thus view clients through the prism of their distress rather than their potentialities (Mearns, 2004). Such a reductionist view is philosophically incongruent within a person-centred perspective, viewing persons as unique and possessing an actualizing tendency promoting growth and enhancement of the organism as a whole.

Person-centred approaches to assessment, diagnosis and case formulation

Despite the many objections to assessment, diagnosis and case formulation, there is much debate within the person-centred framework on how person-centred practitioners may respond to the present context within which such processes are commonplace. Most of the writing around this has focused on assessment, which is often viewed as a process synonymous with diagnosis (Wilkins, 2005a). Mearns (1997), for example, suggests that, from a person-centred perspective, 'the question of assessment is ridiculous: the assessor would have to make a judgement not only about the client but also on the relational dimensions between the client and the counsellor' (p. 91). Others within the approach disagree, suggesting that it is necessary for the approach to find ways to 'articulate' with other models of practice (Joseph & Worsley, 2005) as well as common procedures such as psychometric assessments (Box 27.1). There may also be some benefits to delineating client needs at the outset. This view is strongly espoused by those within the 'experiential' tradition who link assessment and case formulation to the differentiation of different client 'processes' (see, for example, Elliott & Greenberg, 2001).

Those working within the 'classical' tradition often strongly reject the concept of any 'assessment' procedures (see, for example, Bozarth, 1998). However, research by Wilkins and Gill (2003) suggests that, in practice, person-centred therapists within this tradition would also appear to engage in an initial exercise of 'intuitive' information-gathering as part of the contracting procedure. For Wilkins and Gill (p. 183), this seemed to involve, 'arguably at least … an interpretive process – the therapist is using a battery of impressions to form a view as to the nature of the client and the client's experience and using these in a decision making process'. Hence, they argue, it may not be the actual concept of assessment that is so problematic, but its common *purpose* to establish a diagnosis within the 'apparatus' of medicalized distress (Sanders,

2005). Accordingly, they suggest it is possible to disentangle the two and undertake a form of assessment that accords directly with the person-centred emphasis on the *therapeutic relationship*.

Box 27.1

What role should psychometric testing play in a person-centred 'assessment' process?

Psychometric testing is routinely used as part of assessment and diagnostic processes within the mental health field, being seen as a efficient and trustworthy method to identify which, if any, mental health 'disorders' are present within the client, and to monitor the progress of treatment over time. Indeed, in some settings, the use of psychometric instruments has become so enmeshed within clinical practice that to deviate from their use may substantially endanger employment prospects. Psychometric testing can present many challenges to the person-centred approach, not least of which is the external and imposed categories a client is forced to use to represent their experiencing, something which is in fundamental contrast to the phenomenological basis of all person-centred therapy (see Chapter 7).

Many person-centred practitioners eschew the processes of psychometric assessment and are thus faced with a dilemma in the many mental health settings within which testing is commonplace. For Bozarth (1998), it is permissible for testing to become part of person-centred practice – and if necessary at an assessment stage – only when it is used within 'the framework of the therapist's dedication to the client's world and self-authority' (p.128). He identifies three conditions that would allow for this:

- a request by the client, either directly or indirectly, to take a psychometric test;
- the policies of the setting making it necessary for the client to take a test;
- the test offering a means through which a client may use the outcome to support a 'decision for action' affected by external factors.

In each of these, he argues, it is vital for the person-centred practitioner to be honestly 'present' in the process, and thus able to help the client make sense of the outcome in an open, transparent and congruent way, sharing concerns where necessary.

Of course, a further mechanism for addressing the difficulties presented by the approach in terms of 'diagnostic' psychometric measures is the development of alternative instruments more in keeping with the theory and practice of the person-centred approach. This has been an area of much growth in recent years (see Chapter 31 for more information).

The model of assessment proposed by Wilkins and Gill (2003) is based around the person-centred theory of therapy (Rogers, 1957), and constitutes a series of questions through which the practitioner intuitively establishes the likelihood of meeting, with the client, the six 'necessary and sufficient' conditions for change to occur. These questions are as follows:

- Are my potential client and I capable of establishing and maintaining psychological contact?
- Is my potential client in need of, and able to make use of, therapy?
- Can I be congruent in the relationship with the potential client?
- Can I experience unconditional positive regard for this potential client?
- Can I experience an empathic understanding of the potential client's internal frame of reference?
- Will the potential client perceive, at least to a minimal degree, my unconditional positive regard and empathy?

In focusing any assessment process on these questions, Wilkins and Gill (2003) propose an explicitly person-centred perspective in which it is the *potential for relationship* with the client that is being evaluated during an assessment. If the practitioner believes that one or more of these conditions cannot be met with this client at this time, then, in accordance with person-centred theory, therapy will not be successful and further work is thus contraindicated. If, however, the therapist determines that there would seem to be potential for her and the client to meet all of these conditions, this is seen as a basis for therapy with the client.

For Wilkins and Gill (2003), a person-centred model of assessment provides an answer to critics of the approach that it is neglectful of client screening and contracting processes (see, for example, Wheeler, in Wheeler & McLeod, 1995, p. 286), while also presenting a method that can be utilized by practitioners in accordance with person-centred philosophy and theory. Central to the model they outline is, however, an interpretive element – a construct somewhere in the experiential awareness of the practitioner – of the client and their relational capacities and needs in that moment. Although this construct may be evolved relationally and be implicit in form (that is, a felt *sense* of something rather than an explicit conceptualization), it is seen to serve a core role in supporting, essentially, a form of treatment planning in determining whether or not to offer person-centred therapy to the client. This function is similar to that of many case formulations in the psychological domain, informing clinical decision-making with regard to a specific psychological theory of change.

Hence the model provided by Wilkins and Gill may be seen as both an approach to assessment and a tentative framework for the development of a person-centred approach to case formulation. Indeed, such an approach may offer important opportunities for practitioners in enabling a clear mechanism for linking theory to practice in assessment procedures and ongoing therapeutic encounters. In such terms, the 'construct' of the client's experiencing and needs may be developed by drawing on relevant theory and research.

For Wilkins and Gill (2003), one of the most helpful areas of person-centred work in this regard is the seven stages of psychological process identified by Rogers (1961). These stages characterize the degree of incongruence experienced by a client and are accordingly seen as of potential assistance to the practitioner in determining whether or not the 'necessary and sufficient' conditions may be met in a future process. An understanding of these as hypothetically applied to any client may also support the practitioner in deepening their empathy for that client by hinting at their more likely way of being and the implications of this for the building and maintenance of the therapeutic relationship over time. As Wilkins (2005b, p. 143) suggests:

> Together, the necessary and sufficient conditions and the seven stages of process provide Person-Centred Therapy with an assessment rationale for deciding the likelihood of establishing a successful therapeutic endeavour, for monitoring its progress and, to a lesser extent, determining the nature of therapist behaviour.

For Wilkins (2005b), person-centred theory offers both a mechanism for conceptualizing (that is, formulating) a client's needs and informing clinical decision making at the assessment stage. This case formulation also offers the practitioner a theoretically informed means to consider the ways in which the therapeutic relationship with a client might best be developed and maintained on an ongoing basis.

Indeed, in addition to the theory of 'processing' outlined by Rogers (1961), other areas of person-centred theory may be drawn into a case formulation to assist this process. Warner (2000), for example, has shown how different styles of 'processing' can be understood and attended to from a person-centred perspective. Similarly, Lambers (1994) has identified the ways in which person-centred personality theory may provide an understanding of how clients diagnosed with 'personality disorders' may bring particular sensitivities into the relationship. For example, she suggests that clients who are commonly diagnosed with 'borderline personality disorder' may have experienced 'inconsistency in conditions of worth, lack of validation experience, abuse and emotional neglect' (p. 111). Indeed, she goes further to explore the implications of these for therapeutic practice, suggesting that the therapist may need to attend most strongly to their own congruent experiencing to ensure they are able to avoid being drawn into the client's internal conflicts and fears.

All these theoretical insights, in addition to the growing research base, offer opportunities for person-centred practitioners to utilize person-centred theory to support their therapeutic practice. When applied reflectively and hypothetically, they can form a case formulation that may be used to shape how to best meet the therapeutic requirements of the approach with any individual. An example of such an approach to case formulation is in Box 27.2.

Box 27.2

My 'case formulation' of Brian

Throughout his assessment session, Brian regularly offered a clear and stated view that he was only present because his partner wished him to be there. He asked me to 'play along' with him by seeing him a few times and then discharging him. In working with Brian during the assessment, my central concern was whether we could establish a relationship likely to meet all six conditions as stated in person-centred theory of therapy (Rogers, 1957). I was concerned that Brian's apparent lack of distress meant he was not 'anxious or vulnerable', and thus change would not necessarily occur should we undertake any therapy (Embleton Tudor, Keemar, Tudor, Valentine, & Worrall, 2004). In such circumstances, I was concerned that it would be unethical to offer further work.

Intuitively, however, I sensed something in Brian that seemed less sure than his confident assertions seemed to imply. I wondered if this was an *empathic* response to an experience at the 'edge' of his awareness. Furthermore, Brian seemed at times to be able to offer some reflection on himself and his feelings ('I know I am difficult, mainly for myself!'), which seemed more akin to a stage two or even stage three style of processing in terms of the process continuum identified by Rogers (1961). Being mindful that many clients enter therapy with a style of processing akin to that described as stage three, and adding all my intuitive hypothesizing to my knowledge of theories around masculinity and the societal 'conditions of worth' introjected by many men concerning the expression of vulnerability and distress, I developed a tentative formulation of Brian that, in summary, suggested he was someone in greater distress than he was able to admit to himself and others. I accordingly decided to offer further sessions on that basis. During these sessions, we gradually formed a bond that enabled our work to eventually confront painful feelings of shame linked to childhood trauma.

Case formulation and person-centred practice

Although it is possible to demonstrate the potential relevance of a whole range of person-centred theory and research within any case formulation, one of the significant questions that arises in relation to this is how the link between such theory and person-centred therapy works in practice. Rogers (1961) was very clear in prioritizing the client's frame of reference (their own 'formulation') over those held by the practitioner in his eschewal of 'expertness'. Accordingly, from a person-centred perspective, great care must be exercised to ensure that fundamental principles of the approach are not compromised when developing and utilizing a case formulation as part of the therapeutic endeavour.

Most fundamentally, a person-centred case formulation is never prioritized over a client's own perceptions or experiences, and thus resides entirely within the practitioner as a theoretically informed, ongoing and contingent conceptualization of the client as a whole person with particular needs and sensitivities. It is used – always tentatively and hypothetically – to help the practitioner 'make sense' of the client and his or her experiencing, and to enable effective decisions to be made at the stage of assessment and throughout therapy on how best to develop and maintain the relationship.

A case formulation is never imposed on a client, as this would clearly direct the content of the therapy and thus undermine the phenomenological basis of the approach. At times, however, it might be tentatively discussed with a client for whom a conceptual understanding of their experiencing, and the role of therapy in relation to it, is seen to support the development of an empathic, unconditionally valuing and congruent therapeutic relationship. It is not a means of determining any specific 'issues' to be worked on (for example, hypothetical 'conditions of worth'), or a means of prejudging outcomes. While it does necessitate ongoing reference to person-centred theory in the service of a client, it does so in a way that holds knowledge 'lightly' (Wilkins, 2003) and in a manner that does not detract from the moment-by-moment encounter between persons (Mearns & Cooper, 2005).

This existential dimension does, of course, present a challenge to practitioners. Working toward relational depth with all that this encompasses does not, at first glance, seem easily reconciled with the notion of a 'case formulation' offering conceptually derived observations of a client's experiencing and needs. However, for Purton (2004), these processes are not mutually exclusive, and each can therefore form part of the therapeutic endeavour. There is an opportunity for practitioners to move between the realm of unarticulated experiencing or the 'felt sense' and encounter in the moment, and that of reflective, theoretically informed knowledge. For Purton, it is entirely possible to exist within both, being 'open' to whatever unfolds but at the same time being mindful of theories, concepts and previous experiences. Hence the role for a case formulation is one of coexistence within all else that arises within a here-and-now encounter between two persons.

Conclusion

Assessment, diagnosis and case formulation processes lie at the heart of contemporary working within the psychological domain. They are often seen to present a significant challenge to person-centred practitioners in the extent to which they accord with a diagnostic, planned approach to psychological 'treatment' that is as at odds with the primary emphasis placed on the therapeutic relationship. Yet both assessment and case formulation processes can be framed to articulate more favourably with the emergent and relational standpoint of person-centred therapy, allowing practitioners to prioritize the client's 'frame of reference' while at the same time maintaining a tentative, theoretically informed understanding of what the client might be bringing into the relationship. Relating in the here-and-now while remaining congru-

ent to a tentative, theoretically informed case formulation is possible as long as the practitioner remains open to whatever might arise as the process of therapy unfolds.

Points for reflection

- What kind of 'assessment' do you undertake when meeting clients for the first time, and how do you use this process to inform your thinking and decision-making?
- To what extent do you use person-centred theory to help conceptualize what 'sensitivities' a client may bring into the therapy with you, and how could you develop your use of theory and research in supporting your work with clients?
- How could we further develop a person-centred framework for assessment and case formulation? Is there a role for a specific protocol based around the person-centred theory?

Key readings

- Wilkins, P., & Gill, M. (2003). Assessment in person-centred therapy. *Person-Centered and Experiential Psychotherapies*, 2(3), 172–87.

A good introduction to the issue of assessment from a person-centred perspective.

- *Person-Centered and Experiential Psychotherapies*. Special issue on Process Differentiation and Person-Centredness.

A special issue of the journal discussing many issues relating to process differentiation in person-centred therapy. These issues are aligned with those relating to the use of theory and concepts in the practice of person-centred therapy, and thus provide a good backdrop for considering these debates.

- Johnstone, L., & Dallos, R. (2006). *Formulation in psychology and psychotherapy*. Hove: Routledge.

Offers a helpful and insightful guide to the different ways in which case formulations are developed and utilized from different therapeutic perspectives.

- Gillon, E. (2007). *Person-centred counselling psychology: An introduction*. London: Sage.

Explores the person-centred approach from the perspective of counselling psychology, with a specific focus on the challenges and opportunities faced by person-centred practitioners working in 'psychological' contexts in which assessment and formulation processes are commonplace.

- http://en.wikipedia.org/wiki/Clinical_formulation

A webpage that offers a good starting point for thinking about issues of clinical formulation and provides many useful links.

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28

Ethics in practice in person-centred therapy

GILLIAN PROCTOR AND SUZANNE KEYS

This chapter discusses:

- The fluid, dynamic and personal nature of ethics
- The importance of accountability, articulation and dialogue in thinking about our own ethics
- The place of ethical codes and frameworks in therapy
- The ethics of justice, including the principles of respect for autonomy, doing good, avoiding harm and justice
- An ethic of antioppressive practice
- An ethic of relational trust
- How I know I'm an ethical practitioner

Ethics is a fluid, internalized and vital part of our everyday lives, where personal and professional are intertwined. It is about how we act in the world based on what we value and believe. Ethical decisions are triggered by the fact that we exist in relationships, not only with others, but also with ourselves and our environments. The complexity of ethics stems both from the multiplicity of our relationships and from the influences of a cocktail of morals, values, principles and beliefs, which themselves come from a range of cultural, social, political, spiritual and personal sources. Moreover, we make our ethical decisions based on a range of ways of knowing, including rationality, emotion, bodily sense and intuition.

Given this complexity, it is hardly surprising that the area of ethics is often one

where questions have more than one answer and fixed rules cannot be made to fit every situation. Nevertheless, ethics does involve making decisions, which inevitably entails assessments, judgements and choices about what is 'right' and 'wrong'. In writing this chapter, we have been challenged by our tendency to be prescriptive and write how we think a person-centred therapist *should* be. This is the tension inherent in ethics: how to balance what feels right for me as an individual with what may be right for the other or the common good. How do we navigate between the 'soggy sands of relativism' and the 'cold rocks of dogmatism' (Blackburn, 2000, p. 26)? We suggest we can do this by being as aware as we can be of the struggles inherent in the ethical decision-making process, by being open to the range of influences on the process, by being prepared to be challenged and change, and by trying to articulate the process as clearly as we can.

Accountability, risk management and regulation are terms from a culture in which external standards, conformity and suspicion prevail over uniqueness, humaneness and trust. They are nevertheless crucial issues to address in terms of our ethical practice as therapists. To be accountable is to be able to articulate our ethics in a meaningful way to others, to be able to be communicate what we are thinking, feeling, sensing and intuiting about issues and how we use this to make decisions. Risk management involves being aware of the inevitable risks of being in relationship with another person and being open and honest about our fears and responsibilities. Regulation entails openness to the ongoing self and peer assessment emphasized in person-centred training and practice.

Our aim in this chapter is to open up the territory of ethics in the practice of person-centred therapy and to encourage practitioners to find their own ethical path. Ethics comes alive through articulation, discussion and dialogue. It is our hope that this chapter will stimulate such engagement and exploration.

We begin by looking at ethics in the context of therapy, and then focus on some specific moral principles from the perspective of person-centred theory. We then explore how we might know we are practising ethically and finish with an example of ethics in practice, which brings together some of the issues we have highlighted.

Ethics in therapy

Along with the increasing professionalization of therapy have come codes of practice, regulatory bodies and complaints procedures. The claim for this process is that it protects the client. In fact, research and experience have not shown that it diminishes the amount of abuse or harm caused by professionals (Bates & House, 2003). The danger is that a therapist can become so fearful of censure that she loses touch with a sense of her own internal ability to evaluate and make decisions. Strict adherence to codes takes responsibility for the relationship away from the two people involved, which leads to unthinking, unaware and therefore unethical practice.

On the other hand, collective frameworks and guidelines can be vital as a point of reference for therapists in their decision-making processes. Most therapists are obliged to be members of professional bodies that each have ethical codes. In the UK, the

British Association for the Person-Centred Approach does not have an ethical code but states in its accountability policy: 'Every BAPCA member who is also practising as a counsellor, psychotherapist or psychologist is required to be a member of an organization with an enforceable code of ethics' (www.bapca.org.uk). Various professional bodies are listed as examples, including the British Association for Counsellors and Psychotherapists (BACP) and the Independent Practitioners Network (IPN). The IPN offers an alternative framework of ethical peer accountability that does not involve codes but does necessitate ethical reflection and accountability. It is also useful to consider how personal and professional ethics fit in with international ethical statements such as the Universal Declaration of Human Rights (www.udhr.org; Keys, 2000) and the Earth Charter (www.earthcharterinaction.org).

Ethics in therapy has traditionally been based on a primary ethic of autonomy, one of the four principles forming the traditional approach to moral philosophy and biomedical ethics known as the ethics of justice (Beauchamp & Childress, 1994, in Bond, 2010; Banks, 1995). Bond, a key writer and thinker in the field of professional therapy ethics in the UK, has considered the significance of a recent shift to a primary ethic of 'relational trust' in therapy. This move parallels the feminist critique of the ethics of justice as being focused on individuals and not concerned with humans as social and relational beings (Banks, 1995). Bond's working definition of 'being trustworthy' is a helpful way of thinking about an an ethic of relational trust, as a 'striving to form a relationship of sufficient quality and resilience to withstand the challenges arising from difference, inequality, risk and uncertainty' (Bond, 2010, p. 244)). It involves constant awareness and monitoring of the idiosyncrasies of each changing relationship and what Bond refers to as an 'ethical mindfulness': 'a commitment to professional and personal integrity by acting in ways that are informed by ethical sensitivity and thoughtfulness in response to the complexity and diversity of contemporary social life' (Bond, 2010, p. 242).

The ethics of justice

In what follows, we consider the four principles of the ethics of justice alongside the ethics of antioppressive practice and relational trust in the context of person-centred practice and theory. In order to illuminate the complexities of decision-making from different ethical principles, we mention a few of the possible issues that may arise in therapy situations. These examples are not intended to be in any way exhaustive or conclusive. They are the kinds of dilemma that might be discussed in supervision with a trusted therapist where empathy, unconditional regard and congruence are present, where each situation can be explored in its uniqueness, where vulnerability can be revealed and mistakes challenged. This is a vital component of ethical practice.

Principle of respect for autonomy

Rogers' focus on the autonomy of the client, embedded in a phenomenological approach to therapy, was, and is, challenging to those who want to see the therapist

as the expert who will diagnose and 'cure' clients. In person-centred theory, it is the client who is the expert in their world, and the client who leads the process of therapy and who has the resources and capacity to grow constructively and fulfil their potential, given the right conditions. At work here is an underlying belief in the organism's tendency to actualize towards autonomy (Rogers, 1959). It is a biological force and thus 'an amoral concept' (Mearns & Thorne, 2007, p. 181). This belief leads to the central and vigorously debated principle in person-centred therapy of non-directivity. Grant sees non-directivity in clear ethical terms, as being about 'the morally best way of doing therapy'. Principled, as opposed to instrumental, non-directivity is honouring a primary ethic of autonomy, 'essentially an expression of respect' with no preconceived idea about outcome (Grant, 2002, p. 371).

A focus on the primary ethic of autonomy in person-centred therapy has led to criticisms about it being an individualistic approach (see, for example, Proctor & Napier, 2004) that does not consider the consequences of actions on others, does not acknowledge the relationship and obscures awareness of the wider social and political contexts (Box 28.1).

Box 28.1

A scenario: respecting autonomy or relational ethics?

A client does not attend a therapy session and does not contact the therapist. If autonomy is prioritized, the therapist may decide not to contact the client. However, this strict prioritizing does not take into account the relational aspects of the therapy including the quality of the relationship, the level of trust, the importance of the therapist demonstrating their caring for the client and an awareness of the power dynamics. These considerations may lead to the therapist contacting the client.

Principle of doing good or beneficence

Beneficence is a commitment to doing good. It is often explained as promoting the client's wellbeing or acting in the best interests of the client based on professional assessment (BACP, 2010). It is seen as particularly important if the client's capacity for autonomy is limited. In consideration of ethical dilemmas in therapy, the principles of autonomy and of doing good are often presented as being in conflict: the first based on trusting the client, the second based on trusting the therapist to know best.

In person-centred therapy, what is understood to be doing good is to respect the client's autonomy such that principles of autonomy and beneficence are in accordance. An inability to establish psychological contact – one of the prerequisites for therapy to happen – could be seen as a threat to the client's capacity for autonomy within the relationship. Pre-Therapy (Prouty, Pörtner, & Van Werde, 2002) is a way

of working to establish contact with those who might be seen, for example, as 'psychotic' or 'dissociated' or as having 'severe learning disabilities'. This way of working aims to maximize the chances for a client to make the best autonomous decisions possible. In a situation where there is a risk of harm to self or others, all aspects of the relationship and context need to be taken into consideration, including the therapist's responsibilities towards the client, herself and society (Box 28.2).

Box 28.2

A scenario: autonomy, beneficence or relational ethics?

A client is feeling suicidal and the therapist, despite exploring the issues during the session with the client, is left concerned for the client's safety after the end of an appointment. Does she contact the client or another person such as a doctor or family member, or does she wait until the next appointment? Does she trust and prioritize the client's autonomy or does beneficence here mean 'life at all costs', even at the cost of the breakdown of relational trust? Personal values and beliefs about life and death play a part, as do the limits of the therapist herself – knowing what she can and cannot live with. Her assessment of the quality of the relationship and her empathic understanding and acceptance of the client, and also of any systemic or institutional context, will all come into play in this decision.

Principle of doing no harm or non-maleficence

Non-maleficence is a commitment to avoid harm and is often referred to as avoiding exploitation in therapy. Bond suggests that professional ethics are particularly, but not exclusively, concerned with the moral challenges arising from the power imbalance between the therapist and the client (2010, p. 83). It is the therapist's responsibility to be aware of the ways in which they could use 'power-over' (Proctor, 2002, p. 94) the client and not do so.

By prioritizing the principle of respect for autonomy in order to ensure therapy meets the client's and not the therapist's needs, person-centred therapy takes the principle of avoiding exploitation very seriously. However, Proctor (2002) suggests that, in emphasizing the person-to-person equality of the therapy relationship, person-centred therapists are in danger of minimizing or obscuring the power still inherent in the roles of therapist and client. To ensure potential for harm is noticed and taken seriously, it is important that person-centred therapists do not emphasize the agency of individuals at the expense of appreciating the impact of structures of power on our lives.

For example, a therapist may want to respect the client's autonomy by answering a client's question about what the therapist would do in a given situation. However, the therapist may be wise also to consider how much authority the client invests in the role

of the therapist. Although the therapist may try not to behave as an expert, she may still need to check whether the client perceives her response as the 'right' thing to do.

On the other hand, fear of doing harm to a client can lead to risk-averse practice, particularly in increasingly litigious societies. Therapists can become paralysed by fears of doing 'the wrong thing' and of being sued. This can lead them to withdraw, disengage and adopt rigid boundaries in a bid to stay 'safe' and keep the client 'safe'. This underinvolvement (Mearns & Thorne, 2007; Proctor, 2004) is harmful to both therapist and client as it denies the opportunity for person-to-person relating, which lies at the heart of person-centred therapy. Here, flexible boundaries and responsiveness to the dynamic nature of the client's needs, or clarity and openness when a therapist is unable to respond to a client, are important (see Proctor, 2007, 2010).

It is vital to listen, read and learn from clients' experiences of therapy, particularly with those who have felt harmed and abused in their therapy relationships (see, for example, Bates, 2006; Heyward, 1994; Ironside, 2003) (Box 28.3).

Box 28.3

What do clients say?

Themes that emerge from such accounts are the clients' desires:

- for a demystification of therapy;
- for more cooperative, collaborative and co-creative relationships;
- for more recognition of the complexities of the interdependent nature of therapy;
- for more human contact and warmth.

Abuse, according to Heyward, 'is not simply a matter of touching people wrongly. It is, as basically, a failure to make right-relation, a refusal to touch people rightly' (Heyward, 1994, p. 10).

Ethics of justice: principle of justice

The principle of justice refers to treating all people equally and can be applied as the fair and impartial treatment of all clients and the provision of adequate services (BACP, 2010). This concept may conflict with a phenomenological approach in which each therapy relationship is unique. Person-centred therapy cannot be said to be 'applied equally'. Similarly, the notion of 'impartiality' and the principle of justice has been critiqued by feminists as being based on a rational idea of ethics, which does not account for the emotional links or attachments between people in relationships (Banks, 1995). It may, however, be useful to interpret the principle of justice as saying that, within the awareness that each relationship will be different, the person-centred therapist has a responsibility to be equally open to a therapeutic relationship with each client.

This principle also indicates a responsibility for person-centred therapists to be aware of issues of access to their services and to allocate services without discrimination or judgement. This requires an awareness of discrimination in society and how this may affect access – all people are not equal in their situations. For example, have therapists considered access to therapy for people who use wheelchairs, who are visually impaired or who require interpreters? This awareness changes an interpretation of the principle of justice to suggest that situated knowledge rather than impartiality is necessary for the just or fair treatment of people. This is the basis of an ethic of antioppressive practice.

Ethic of anti-oppressive practice

To act from this ethic, a therapist needs to be continually aware of how, for example, the social, cultural and religious environments of both therapist and client create a complex interplay of power dynamics within the relationship. This is where a person-centred therapist needs to acknowledge the power of their role as therapist, in addition to other structural positions of power they may hold (see Proctor, 2002). The key consideration relates to being aware of how this power may become oppressive to the client and trying to ensure that this does not happen (Box 28.4). This demands an openness on the therapist's part to exploring their outer as well as their inner world, to hearing feedback on how they are perceived by others, to being honest and challenging their fears, assumptions and prejudices, to acknowledging their powerfulness and powerlessness and to being ready to change.

Box 28.4

A scenario: an ethic of anti-oppressive practice

An able-bodied, white, Christian therapist working in the UK with a person who is physically impaired and from a minority culture and religion needs to be aware of how they might each experience power in relationships differently and how this may be enacted in their relationship. Any ideas of what empowerment means must come from the client rather than being based on any preconceived ideas of the therapist. The therapist's continual mindfulness of her own prejudices and assumptions is important, as is her ability to proactively engage with the client on these issues (see Keys, 2006).

Ethic of relational trust

Relational trust, according to Bond (2007), is 'situational' and 'requires continual ethical mindfulness, active responsibility and accountability as situations arise'. 'Ethical education and awareness are paramount rather than excessive reli-

ance on rules.' 'The quality of relationship is foregrounded for active reflection in the therapeutic process and is a basis for client's innovations in feeling, thinking and acting.'

Meta-analyses in psychotherapy research indicate that often, regardless of the theoretical approach, it is the quality of the relationship that heals (Cooper, 2008), pointing to the importance of an ethic of relational trust. One of the relational factors that has been found to be 'probably effective' is 'the capacity to repair alliance ruptures' (p. 120; see also Norcross, 2002, pp. 3–16). This is very significant in the context of ethics because it underlines the importance of the engagement of both therapist and client in facing difficult and challenging dilemmas in their relationship. An ethic of relational trust leads to an emphasis on mediation and dialogue in cases of relationship breakdown. Totton is of the opinion that most complaints would be avoided if we focused on how to repair breakdowns through acknowledgement of hurt and dialogue (2012, p. 18).

Recently, person-centred theorists have focused on the relationship rather than on the therapist or client individually (see Chapter 5). Relational and social factors are given more weight, and therapy moves beyond the private and the individual, becoming not only an ethical, but also a political, spiritual and existential activity.

The necessary and sufficient conditions of the therapeutic relationship

If we look at Rogers' 1959 conditions for a therapeutic process, contact and perception (Wyatt & Sanders, 2002), are as important as the often overemphasized 'core conditions' of therapist congruence, empathy and unconditional positive regard. They give the context for the conditions as relational concepts or principles. Congruence, empathy and unconditional positive regard within an ethic of relational trust are seen as more than attitudes held by the therapist towards the client, instead being the very fabric that makes a relationship safe, trustworthy, healing and therapeutic. These attitudes come alive through reciprocation and a working together of therapist and client. Thus, an ethical person-centred therapist no longer sees herself as offering the conditions but as being continually mindful of the quality of the relationship being co-created between herself and the client.

Congruence

The ethics of congruence arise from the interplay of the therapist's openness to self and her ability to acknowledge and articulate this meaningfully in relationship. She needs a commitment to challenging what may be denied, distorted or subceived within herself, but also to being in tune with how congruent the relationship is with the client, how truthfully she is being perceived by the client and whether and how to verbalize any of this. This suggests that self-awareness, courage, openness, honesty, truthfulness and integrity are important values for the person-centred practitioner. I

am working ethically when I am in 'right' or congruent relationship with my self and the other in all our fullness and complexity.

This can have a political aspect for those who see the person-centred approach as a way of being. Every aspect of living is seen as needing to be congruent with the core values and principles. This may lead to political activism as in, for example, Rogers' work for peace and reconciliation, which led to his being nominated for a Nobel Peace Prize. Likewise, incongruent practice and living can be seen as unethical.

Empathy

The ethics of empathy in the context of relational trust in therapy requires a therapist to be able to be congruent, self-empathic and self-accepting while also being able to be in the world of another person. There is tension here between self-awareness and self-forgetfulness – being present to oneself and to the other. Being empathic to different worlds extends to the range of external and internal environments that both therapist and client occupy. Some of the values implied in the ethics of empathy are those associated with unconditional positive regard: care, respect and humility.

Unconditional positive regard

The tension inherent in the ethics of unconditional positive regard lies in the paradox that change happens through acceptance. This is a radical ethic in terms of relationship in that it requires a therapist to accept all parts of a client equally, even their 'not for growth' parts (Mearns & Thorne, 2007) and to see everyone as worthy of the utmost respect or, as Thorne puts it from a spiritual perspective, as 'infinitely beloved' (2012, p. 247). This is equally true of the therapist's attitude to herself, and it could in fact be seen as an ethical imperative for the therapist to work on her self-love as much as on the nature of her love for her client (Thorne, 2012).

A theoretical development of unconditional positive regard that puts it firmly in the context of an ethic of relational trust is the notion that as human beings, there is, alongside our 'universal', 'pervasive and persistent' need (Rogers, 1959, p. 223) *for* unconditional positive regard, also a basic need to *express* unconditional positive regard to others (Brazier, 1993; Thorne, 2002) and to have that received. This highlights the significance of a therapist respecting and responding to a client's need to express their caring or loving within the therapy relationship. This challenges some of the long-standing 'ethical' rules in the psychotherapy world, which, for example, consider receiving gifts from a client as always transgressing professional boundaries.

Mutuality

Mutuality is a characteristic of an ethic of relational trust. It is the process whereby both therapist and client are open to being changed in the relationship (Jordan, Walker, & Hartline, 2004). It implies 'some reciprocity in the relationship between therapist and client … as regards understanding, power and humanity' (Tudor &

Merry, 2002, p. 86), although it does not deny the asymmetrical nature of the therapy relationship (Aron, 1996). Proctor (2004, 2007, 2010) emphasizes the practitioner's awareness of her own needs and limitations in an ethic of mutuality. In this context, a therapist is aware of her limitations as a basis for her boundaries and can acknowledge these to the client while at the same time being able to negotiate co-created boundaries specific to the relationship that are flexible and open to renegotiation.

The therapist aims to respond honestly and with care to the needs of clients while being aware of and also prioritizing her own needs. Can she be flexible and dynamic in arrangements with clients and open to reconsidering any decision made concerning a therapy contract, in terms of timing of sessions or any other factors? Therapists do have restrictions on how much they can offer clients, perhaps due to the services they work within and due to personal limitations: emotional, practical and financial. However, the key here is for therapists to be honest about these limitations, and to work with the client to negotiate between each of their needs. So, for example, if a client wants more frequent or longer sessions, the therapist needs to be clear about why she can or cannot do that. Equally, if she is unsure about what she feels in the moment, she can express this and take time to think about or discuss her response with her supervisor.

How do I know I'm an ethical practitioner?

To keep asking this question is in itself an indication of ethical practice. It is in the ongoing openness to others through questioning and exploration – with clients, in supervision and in personal and professional development – that we can trust that we are practising ethically. This questioning and reflecting on practice is not the same as self-doubt and self-criticism, which can be undermining and disabling. For a reflective practitioner, the emphasis is on growing self-awareness and ongoing openness to challenge and learning. A key question to ask is how in touch we are with what may be on the edge of our awareness and those areas of our lives where we deny, distort and subceive experiences.

An example of this is sexuality, an area where the conditionality of many societies and cultures means that there are often incongruencies between our organismic experiencing and what we allow into awareness. It is essential that, as therapists, we are aware of the sexual component in our therapy relationships and are open to discussing this in supervision. If it is denied, the resulting incongruence is unethical and we become untrustworthy as practitioners (Schmid, 1996).

A charge levelled against person-centred therapists might be that, in trusting ourselves and the client and in valuing idiosyncratic practice (Keys, 2003), we practise an 'anything goes approach' in which the individual's unique understanding outweighs any external codes or constraints. This makes no sense in the context of relationship and the definition we have given of ethics in this chapter as decisions are never taken from a purely individualistic point of view.

In person-centred theory, the organismic valuing process 'describes an ongoing

process in which values are never fixed or rigid, but experiences are being accurately symbolized and continually and freshly valued in terms of the satisfactions organismically experienced' (Rogers, 1959, p. 210). These 'satisfactions' must be seen in a context where there is social mediation of the actualizing tendency (Mearns & Thorne, 2007) that takes into account the constraints of external factors and social realities (Tudor & Worrall, 2006). Therefore, to be ethical as a person-centred therapist demands that a high degree of self-awareness is grounded in an awareness of context. The awareness, for example, of the power differential inherent in the therapy relationship and the prioritizing of a client's needs would suggest that behaving sexually with a client is never likely to be therapeutic. An awareness of the institutional or systemic contexts we work in also informs how we make ethical decisions with clients.

An example of ethics in practice: ethical considerations

A long-term client is very distressed during a session and talks particularly about how alone she feels. At the end of the session, the therapist wants to reach out to touch the client. In the moment, she may touch the client or let her know that she would like to do this, either verbally or non-verbally.

From a primary ethic of autonomy, the therapist would consider that it is important that the client must decide whether or not she wants to be touched. Consideration of this principle alone would suggest that the therapist should not touch the client unless this touch is initiated by the client.

From an ethic of antioppressive practice, however, the therapist is aware of the dynamics of power in the therapy relationship. The client has let the therapist know that she finds it difficult to trust anyone, having had much previous experience of being judged and treated with no respect. The therapist is aware that the client feels unable to ask for anything in most of her relationships, feeling unworthy of care, and feels guilty using the therapist's time, so it is unlikely that she would feel able to ask for physical comfort even if she wanted this. She is also aware that the client's experiences of belonging to oppressed groups make it even more unlikely that she will ask for care.

From an ethic of relational trust, the therapist considers her decision in the context of their relationship. What is happening in the immediacy of the relationship on that day? What has gone before? What is the quality of the relationship? Can they talk about what is happening in the relationship? Would the relationship withstand it if the therapist's touch were inappropriate? Would not touching be a denial of the quality of the relationship? What is the sexual dynamic in the relationship? Could the touch be misinterpreted as a sexual advance?

The therapist considers her own emotional responses within the relationship. Given the level of the client's distress, does she herself want some kind of comfort in this situation? She is aware of where her own views on physical touch come from in terms of her history and experiences and the value she places on touch. Is she responding to the client's emotional need, which she is aware of through her empathic experiencing of the client both on this occasion and previously? Are there conditions attached to her touch?

To assess these questions and the risks involved, the therapist relies on her own self-awareness in the context of her relationship with her client (congruence) and her unconditional positive regard and empathic understanding of the client, her self and the relationship. She considers external factors to further evaluate her decision. What would her supervisor's response be? If she is a member of a professional body, what can their ethical framework add to her considerations? Her ethical processing continues after the session as she writes up her notes and discusses it with her supervisor.

The therapist remains open to the fact that in another session at another time with the same client her response may well be different. This experience does not therefore become a rule or a generality, thereby allowing for the fluidity of the person, the relationship and the process.

Conclusion

This chapter explores ethics as a dynamic, complex and evolving decision-making process. Ethics in therapy is particularly important because the therapist's role comes with power, and with this comes responsibility and accountability. We have explored the shift from a primary ethic of autonomy to one of relational trust, while not negating the importance of autonomy in person-centred therapy. We have also highlighted the consideration of an ethic of antioppressive practice. We suggest that a commitment to continually analyse our therapy relationships from an ethical perspective, an ability to live with ambiguity, fear and risk, and an acknowledgment of our limitations is the foundation for becoming ethically mindful, reflective, responsible practitioners.

Points for reflection

- If you respect the autonomy of the client, should the therapist ever initiate a conversation in therapy?
- What do you consider in deciding whether to answer a client's personal question about you, such as whether you are in a relationship?
- A client asks you if you will meet for a coffee after therapy has ended. How do you respond?

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29
Counselling across difference and diversity

COLIN LAGO AND TATSUYA HIRAI

This chapter discusses:

- Challenges to successful therapy raised by the presence of difference and diversity within the therapeutic relationship
- An operational definition of difference and diversity
- The important therapeutic practice ideas underpinning the 'ethnic identity development' and 'therapist development' models
- A general guide to ideas and behaviours that support sensitive multicultural therapeutic practice

Historically, the person-centred approach was conceived as a sufficient and satisfactory therapeutic form for all client populations. The approach offered a model that conceptualized a sensitive interpersonal therapeutic relationship, and it was supported by good research evidence (Stubbs & Bozarth, 1994). However, this assumptive tendency to treat all clients the same was described by Wrenn (1962) as 'culturally encapsulated' counselling, reflecting the fact that little attention was given to the particular and specific needs of individuals from minority populations.

(For further discussion outlining the 'multicultural' criticisms of the person-centred approach raised by a number of authors, including Brodley (2004), Chaplin (1998), Holdstock (1993), Khoo, Abu-Rasain and Hornby (2002), Laungani (2004), Moodley, Lago and Talahite (2004), O'Hara (1996) and Proctor (2004), see the corresponding chapter in the previous edition of this Handbook.)

In recent decades, many psychotherapy professionals across the theoretical spectrum have begun to pay much more attention to 'multicultural' counselling, which

has been described as psychology's 'fourth force' (Pedersen, 1991). This emerging emphasis (particularly in the USA, Canada and the UK) has somewhat reflected changes in:

- national demographics (Sue, Capodilupo, & Holder, 2008);
- attitude change in society (Inglehart & Welzel, 2005);
- developments in legislation towards equality of opportunity for all;
- more professionals from diverse groups being trained as counsellors;
- increased attention to practice and scholarship;
- professional ethics: placing the profession's fundamental ethical principles and virtues at the forefront of professional concern.

A substantial body of research evidence exists demonstrating unequivocally that persons deemed to be 'different and diverse' experience oppressive and discriminatory behaviour from the 'majority' society. These patterns of discrimination are, sadly, evident in every facet of sociocultural life: education, employment, medicine, social work, policing, the judiciary and penal system, and so on (see, for example, Halpern, 2004; Harris, 2004; Mason, 2001; Pilkington, 2002; Read, 2004; Willie, Perri Rieker, Kramer, & Brown, 1995).

The central question that drives the concerns of this chapter is: 'What guarantee do we have, as a professional body of therapists, that we will not repeat these same patterns of discriminating behaviour in our therapeutic work with minority group clients when so many others in 'caring' services have been found wanting?

Counselling across difference and diversity demands that therapists enhance their awareness of their own identity, therapeutic skills development and attitudinal base, as well as develop their knowledge of the specific minority client groups they work with. Implicit in this enhanced sensitivity and knowledge will be an understanding of the myriad of discriminatory mechanisms that pervade society (and thus the individuals within it), and a commitment and willingness to seek new language(s) and behaviours that are respectful and antidiscriminatory for all clients. To explore these issues, therapists, particularly those from 'majority' groups in society, may well have to face major challenges to their assumptions, views and preconceptions (Lago, 2010; Lago & Smith, 2010; Moodley & Lubin, 2008). Extensive new research support for the importance of understanding culture in psychological development and concepts of mental wellbeing and illness can be found in the new fields of global psychology (Cheung, van de Vijver, & Leong, 2011) and cultural psychology (Heine, 2007).

Towards a definition of difference and diversity

The terms 'difference' and 'diversity' have, surprisingly, seldom been defined. The Equality and Diversity Forum of the British Association for Counselling and Psychotherapy (BACP; 2004, p. 1) produced a working definition of these concepts and ventured a listing of those groups deemed to be privileged, 'different' and 'diverse' within society:

There are particular groups which are privileged in U.K. society. These groups represent the often-unexamined norm from which 'difference' is defined. For example:

Advantaged/Norm includes white people, heterosexual people, able-bodied people, men and people of working (income generating) age.

Disadvantaged/different includes black and minority ethnic people, lesbian, gay and bisexual people, disabled people, women, young people/older people/unemployed people.

As may be seen from the above statements, there are a considerable number of categories of persons deemed 'different' or 'diverse'. Each group or category (for example, gay and lesbian people, disabled people and so on) will have their own 'languages', politics, knowledge and models of being, and therapists will be at a considerable disadvantage if they do not possess some competence within these specific fields of application. The above categories also do not refer to client groups who originate from other cultures (for example, asylum-seekers, international students and so on). Moodley and Lubin (2008) refer to all these categories as the 'big seven stigmatized identities' and explore the further therapeutic challenge with those who experience being at the intersection of two or more of these identities (for example, a black Muslim disabled lesbian woman). Continuing the theme of intersected identities, and interestingly almost uniquely within person-centred literature, O'Hara (1996) notes a client's (Sylvia) internalized racial preconceptions as well as the importance of gender in her 'becoming a person'. (Readers may wish to explore these issues further through conducting their own analysis of the video recording of Rogers and Sylvia.)

This brief section has already hinted at the considerable challenges faced by multicultural therapists as well as those who train them. By defining culture too broadly, we lose more and more practicality in counsellor education. We feel that it is almost impossible or arrogant to master awareness, knowledge and skills across all kinds of culture – from ethnographic to religion. Even one of these cultures is complex and profound enough to try to understand. At worst, we fear that the reaction of students to multicultural counselling will either be to grasp the concept of culture at a very simplistic and superficial level, or to become so overwhelmed that they feel helpless or confused in learning multicultural counselling because the areas they are supposed to learn are too broad.

Diversity and difference are relational

Meta-research on counselling and psychotherapy has revealed that the relationship between client and therapist accounts for 30 per cent of the success outcome variables in therapy (Lambert, 1992; Lambert, Shapiro, & Bergin, 1986). By contrast, only 15 per cent of the success variables are accounted for by therapists' theoretical perspective and techniques.

The person-centred approach is espoused as a two-person theory and focuses considerably on relational factors. For the client these are:

- an impulsion into therapy created by their sense of distress and incongruence;
- that they and the therapist achieve psychological contact;
- that they perceive the therapist as relationally responsive and attentive.

For the therapist, there are the attitudinal and behavioural perspectives of:

- acceptance of the client;
- an empathic attitude towards the client;
- a genuineness in their relating to the client.

The 'approach' is thus uniquely poised to equip therapists with a 'relational' modus operandi for working with all clients, wherever they hail from. Its great contribution is that it names, in the above therapeutic conditions, some of the component parts of the helping relationship.

However, where a therapist is working with a client from a different or diverse group, what the theory does not take into account are:

- the therapist's own comfort and competence in working with the particular client; for example, if the therapist has strong negative feelings towards the group from which the client hails, how might he or she offer warmth and acceptance? How might the therapist then manage congruence or transparency in relation to the client?
- the client's previous experience of relating to and working with someone either from the majority group or from outside the group to which they belong.

Can a therapist coming from the 'majority' or a different minority group within society truly and empathically indwell in the minority client's experiencing and views of the world, particularly if those views are alien to the therapist's? Can the therapist create a 'good-enough' relationship with the client that they may work well enough together? Might the therapist, however inadvertently and unconsciously, repeat behaviours and views that have negatively impacted upon the client previously? These questions, and many more, have great consequences, in practice, for the outcomes for the client. There is a constant danger that the client will be exposed yet again to all the discriminatory mechanisms which they may be so familiar with and deeply hurt by. In short, the creation of a relationship that is trustworthy, therapeutic and non-discriminatory between two persons of 'difference' is such a profoundly important therapeutic aim, yet it may be riven by immense complexity in practice.

Whose is the difference anyway?

What Jennifer was saying was that she accepted who she was, including the deaf part of herself. Her experience of disability came from expectations placed on her

> to conform to the common stereotype of deafened people and assumptions that her deafness must be the most important aspect of her life. She said later: 'I wouldn't experience being deaf at all if they allowed me to continue being who I am. Really, the deafness belongs to them'. (Corker, 2003, p. 45)

The above section introduces the very important concept of the relationship of difference and diversity to those not deemed as different and diverse. The terms *different* and *diverse* exist only as descriptions for those who are not deemed to be different or diverse. Inevitably, in meeting, both parties may become implicated in the co-construction of difference. The client from the 'minority' group may well adopt a form of *proxy self* that is assumed when meeting members of the dominant group (Lago & Thompson, 1997). Similarly, the therapist from the majority group may be so anxious about how they respond to the minority client that this anxiety then affects their self-presentation (Buckley, Hardy, Buchan, & Lewis, 2004). Inevitably, these dynamics will impact upon the ensuing quality of the relationship.

While acknowledging this effect of co-construction between the minority group client and the majority group counsellor, we are keen here to focus the spotlight on the therapist and the nature of their attribution of 'difference' towards the 'other'. Seeing and naming the 'other' as different profoundly affects the comfort levels and manner in which the therapist embarks upon their work with the client. The quote used above to introduce this section exemplifies this further. Disability, in this case, belongs to the perceiver, not the perceived. Indeed, in transforming the words of the old saying, 'beauty (and difference and diversity) is in the eye of the beholder'.

Difference and diversity are determined by the majority culture. Sadly for those named, measured and judged subject to such aspersions, they may suffer considerably and systematically, in the material, social and psychological realms, via various discriminatory behaviours (for example, broadly defined as sexist, racist, disablist, ageist, homophobic and so on). The power and dominance positions of society that are reflected in and evidenced by repeating patterns of discrimination and oppression are inevitably also present (although not necessarily always tangible) in the micro-meeting system of dominant group therapist and minority group client.

Identity development

Various models of 'ethnic' identity development have been being developed within the USA since the late 1980s and early 1990s (Atkinson, Morten, & Sue, 1989; Cross, 1991; Helms, 1990, 1994; Phinney, 1990). These models have been developed for a wide range of groups, including in:

- minority ethnic identity development;
- adolescent ethnic identity development;

- black identity development;
- Asian-American identity development;
- Chicano identity development;
- white racial consciousness identity development.

In essence, these psychological models posit five stages of identity development for those in society who hail from both 'majority' and 'minority' groups. The models strive to describe the process of increasing awareness (identity development) that persons may proceed thorough, from an initial stage of unawareness of who they are (in relation to the contrasted group), moving through the stages until a later and comfortable state of awareness about oneself (in relation to both those from one's own group and other groups) is reached. Notwithstanding a critique of these models (that is, that they are 'stage' theories, and as such, do not account for the full complexity of human experiencing and fluidity), they do offer a conceptual framework from which thinking may be generated about identity in relation to others in society. One further critique of these models is that they do not, and indeed cannot, account for those who occupy the position of multiple oppressions, for example persons who are disabled, of minority ethnic origin and elderly.

Extensive research evidence is provided by Carter (1995) to show that the levels of development of identity awareness within therapists can be critical to the outcome of the therapy process – where therapists are at the same stage or at least one stage of development ahead of their client, it is more likely that there will be a more successful outcome to the therapy. As Carter has noted, it is not your ethnicity per se that matters (in therapy), but your psychological resolution to it that is critical.

Pontorotto (1988) developed a model that applies to counsellors and posits increasing levels of sophistication and sensitivity to multicultural issues in practice that are worthy of consideration by therapists concerned with their continuing professional development in this realm. He defines the four stages as:

1. *Pre-exposure:* Counsellors in this category have not considered counselling as a multicultural phenomenon and consequently treat all clients the same.
2. *Exposure:* The therapist embarks on understanding the issues within transcultural work.
3. *Zealotry or defensiveness:* Counsellors may react enthusiastically to this new awareness and become very active, or may retreat into a defended position and continue as before.
4. *Integration:* The therapist acquires a respect for cultural differences and becomes more aware of their own personal identity and how it impacts upon their work (see also Box 29.1). This stage can bring with it a commitment to ongoing learning about this arena.

Box 29.1

Matching therapists and clients on ethnicities

Some modest research in the early 1990s pointed to a possible effectiveness of therapist–client matching, but this work has been substantially surpassed by the recognition that what is of most importance is that the counsellor is 'culturally sensitive' to the client. These findings have recently been supported by evidence gathered by Dutch psychologists at Utrecht University (Knipscheer & Kleber, 2004). Various definitions of what constitutes 'cultural sensitivity' are elusive, although several authors (d'Ardenne & Mahtani, 1989; Lago, 2005, 2010; Ridley, 1995; Sue & Sue, 1990) elucidate desirable key elements of knowledge, skills and attitudes.

A more recent and extensive overview of the research in this area has revealed the extent to which 'ethnic matching' is an extremely complex phenomenon, and while a naive view might be that clients and therapists who are (apparently) similar might work more successfully together, there are considerable organizational challenges to administering and forecasting the success of such working relationships (Farsimadan, Khan, & Draghi-Lorenz, 2011).

The psychological impact of being labelled as 'different' and 'diverse'

> My first experience of queerness centred not on sexuality or gender, but on disability. Early on, I understood my body to be irrevocably different from those of my neighbours, playmates, and siblings. Shaky; off-balance; speech hard to understand; a body that moved slow, wrists cocked at odd angles, muscles knotted with tremors … I heard: 'wrong, broken, in need of repair, unacceptably queer,' every day, as my classmates called out cripple, retard, monkey; as people I met gawked at me; as strangers on the street asked, 'what's your defect?': as my own parents grew impatient with my slow clumsy ways. (Clare, 2001, p. 361)

Eli Clare (2001) goes on further to explain how he came to believe that his 'body was utterly wrong', to the extent that he wanted to cut off his right arm so that it would not shake. In similar circumstances, we have known of clients who have attempted to scrub their dark skin white, or who have coped with their feared homosexual tendencies by completely removing themselves from any friendly or social contact with persons of either sex.

Inhabiting the position of being 'different' or 'diverse' may mean a life lived in fear, continually exposed to negative attitudes and behaviours on the part of mainstream society, and with impoverished life opportunities. As suggested in the identity development models earlier in the chapter, persons from minority groups at the first

stage of development have little awareness of these oppressive dynamics and will identify with the majority group in society and its attitudes. They will believe that they and persons like them either deserve these attributions or that society is fine and there's no problem.

However, as people become sensitive to, and aware of, these societally embedded and reinforced 'slights' or 'put-downs', they begin to recognize the negative, corrosive effect these have had on their own personality structures. In addition, such negative attributions from others may become introjected (incorporated) into the 'diverse' person's psyche (as exemplified in the quote below), so that part of them also internalizes and identifies with society's negative attributions (Box 29.2).

Box 29.2

The impact of internalised oppression

> The women I had met at the disco with David were either so butch they looked like they could donate to a sperm bank, or so feminine they appeared to be in drag, and congregated together at the bar while their butch girlfriends played pool together and fought with each other, drunk out of their minds. I now know it was a kind of self-protection – that lesbians experienced so much hatred from others that they internalised most of it, and tried to become invisible by aping heterosexual couples. (Bindel, 2005, p. 9)

In extreme forms, this (introjection/incorporation) may lead to self-hate or a wish to radically change that part of the self which has attracted these negative assertions (as is evidenced by Eli Clare's statement above). Many who are defined as 'different and diverse' will have experienced teasing, exclusion and victimization. Frequently, they may experience the further insult of feeling and/or being blamed for being a 'victim'. This fundamental denial of responsibility by society further damages the victim, who subsequently internalizes irresponsibility and self-blame. They are thus exposed to a three-level attack on their sense of self, an experience of triple jeopardy. Various writers have named these harmful introjections as:

- internalized oppression (Alleyne, 2004);
- internalized oppressor (Alleyne, 2004);
- identity wounding (Alleyne, 2004);
- transgenerational haunting (Sutherland & Moodley, 2010);
- oppression sickness (a term originating from the gay rights movement);
- recognition trauma (McKenzie-Mavinga, 2009);
- a collective clinical depression of oppressed groups (West, 1993).

The journey from 'oppression' to 'liberation' for any client deemed to be 'different' and 'diverse' is potentially a long and frequently painful journey. Hopefully, this

process will ultimately prove a deeply rewarding and life-changing experience. This journey will inevitably heighten the person's sensitivity to all of society's attributions, both overt and implicit.

A recent handbook of research in social psychology (Forgas & Williams, 2002) conjectures that there are three aspects for the self:

- the individual self;
- the interpersonal self (who one is in relation to friends and relatives);
- the social self (one's relationship to the wider world).

This delineation of different notions of self is not, of course, the same as Mearns' (1999) developmental ideas of configurations of self, but this tripartite separation nevertheless raises interesting ideas about the psychological interrelationship between these three domains.

Might, for example, a therapist from the majority culture (1) classify their individual self as one that is accepting of all others, (2) indeed have some friends who are 'different' and 'diverse', and yet (3) also hold negative views of particular minority groups in the world? This tripartite model of selves advanced by Forgas and Williams (2002) facilitates a method of understanding what are often complex contradictions in our own belief systems. At the three levels, different attitudes and beliefs may pertain.

Research by Dhillon-Stevens (2004) revealed that white therapists seldom examined their attitudes towards their own and others' ethnic identities within their training therapies (an aspect of the social self?), but rather focus on material from their individual and interpersonal selves. It is curious yet comprehensible within this threefold conceptualization of selves to appreciate that white therapists in training will pursue 'self-awareness' and self-exploration through their own therapy experience, yet may not ever touch upon their attitudes towards those who are 'different' and 'diverse'. This research by Dhillon-Stevens further substantiates the necessity for therapy training courses to address seriously these issues of social context and diversity.

At the time of writing this chapter, the major professional body for counsellors and psychotherapists in the UK has initiated a new enquiry into the lack of systematic attention given to social contextual issues in therapy within many professional training courses. It is hoped that the recommendations and findings emerging from this enquiry will influence the training field. In addition, the new text by Lago (2011) contains three chapters dedicated to incorporating training developments sensitive to social context and systematic oppressions.

A good number of salutary research findings are proffered in the different chapters of the *Social Self* (Forgas & Williams, 2002). Quoted below are just a few of the findings that affect people who have been or are socially excluded:

- Medical research suggests that mortality from nearly all-physical diseases is higher among people who are single and/or lack a network of close relationships than among people who have close relationships.
- Mental illness is likewise significantly higher among people who are alone.

- Suicide rates are higher among people who are alone than among those with a network of relationships, and suicide is especially likely among people who have recently lost close relationships.
- Being numb might be preferable to feeling pain, anxiety and sadness, so people shut down quickly when confronted with the distressing experience of social rejection.

There are considerable implications in this last statement for (diverse) counselling trainees who have experienced exclusion and discrimination. The training process opens them up to their emotions, to their own backgrounds and to other's views of themselves and the world. These intense personal and group dynamics can produce both certain volatility in and silent withdrawal from engagement in the training environment for those students who have been previously excluded, disenfranchised or discriminated against by society (Watson, 2005). Watson's doctoral research proves extremely depressing reading for those committed to providing quality training experiences for those who are different and diverse. Rather than learning through engagement with the training group, minority group students tended to withdraw into silence for fear of further hurt and misunderstanding. Many end up, sadly, choosing the silent route to qualification.

In this, we are faced with the sheer complexity of all individual change. To unfreeze attitudes that have become central constituents of the self, our sense of identity itself is attacked at a deep primary level. Matters of difference and diversity, when discussed in training environments, have the capacity to evoke considerable anxiety, fear and apprehension. It may only be at such times as this, or when faced with a client who is so challenging to the therapist in their difference, that the therapist is forced into a recognition that the person-centred approach, however attractive it is as a humanistically embodied theory, may not be sufficient in and of itself. Personal, social, societal and political awareness are all required in working optimally across difference and diversity.

On being part of the dominant majority

Many therapists belong to 'dominant' groups within society. In the Western world, a considerable number will be classified ethnically as white. White, male, middle-class, heterosexual, able-bodied therapists occupy the dominant societal power position (according to the BACP definition of diversity quoted earlier in the chapter). Although not predominantly male (as 83 per cent of BACP's membership is female), there is a frequent assertion that most therapists hail from white, upper and middle-class backgrounds. The costs incurred through counselling and psychotherapy training, for which little or no other funding is available to trainees other than personal finances, inevitably lead to a situation where those of impoverished means are less able, and thus less likely, to embark on a course of training.

To be part of a group that holds power is for many an experience completely

out of awareness. For them, this is just how life is. It is the unquestioned norm. Consequently, being part of a majority has attracted little social scientific attention until recent decades. Richard Dyer sums up a component part of this apparent non-seeing of the obvious in his book *White* (1997). In it, he asserts that *whiteness* has so long been assumed to be the position from which everything was judged, that it has set a norm:

> The invisibility of whiteness as a racial position in white (which is to say dominant) discourse is of a piece with its ubiquity … Research – into books, museums, the press, advertising, films, television, software – repeatedly shows that in Western representation, whites are overwhelmingly and disproportionately predominant, have the central roles, and above all are placed as the norm, the ordinary, the standard … there is no more powerful position than that of being 'just' human. The claim to power is the claim to speak for the commonality of humanity. Raced (different and diverse) people can't do that – they can only speak for their race. (Dyer, 1997, p. 2)

Penetrating this 'norm' is an extremely challenging task as it is multilayered, opaque and difficult to catch (see Lago, 2005). Nevertheless, in following the dictum 'know thyself', this chapter strongly urges 'majority group' therapists to explore the significance of their majority group status, particularly as it relates to those in various minority positions.

Key recommendations for person-centred therapists working across difference and diversity

> A [counselling] trainee who is a wheelchair user reported that he had to phone 35 therapists before he could arrange to meet one that was wheelchair accessible. His choice of therapist is reflected by his ability to find one that he can actually meet, face to face and this impacts on his ability to make an informed choice in finding a therapist he feels he can work with. (Dhillon-Stevens, 2004, p. 54)

This quotation above immediately grasps our attention. Working with clients from 'diverse' communities requires that we completely have to re-contextualize our therapeutic work, from the primary moment of contact through to completion.

Responding to the individual client

- 'Retain a strong ideographic stance towards your client' (Ridley, 1995, p. 82). In short, this means 'respect each client, their uniqueness and their story'. (Despite the apparent 'crassness' of this very obvious statement, given the nature of this complete text, there are sufficient evidences of practice that do not meet these criteria.)
- Remember that when your client is from a 'different and diverse' group from yours, this may not be what they are seeking counselling for.

- Listen deeply to the experiences of those who have suffered because of their differences. Do not gainsay it, even when your experience runs counter to anything they claim. Strive to understand it. (The strong emphasis on empathic listening with the person-centred approach is critical here in theoretical terms, but the challenge to the therapist, in practical terms, to maintain this stance when they feel that they and/or their group is under criticism or attack is very considerable indeed. Such episodes represent a schism between theoretical intention and clinical practice.)
- Strive not to be avoidant of the difference and diversity the client represents. Recognize and acknowledge it. Meet it squarely when the client raises it.
- Some counsellors have found the process of *associative identification* useful when establishing relationships with different and diverse clients; that is, they search for elements of similarity between themselves and the client to forge the therapeutic relationship.

Continuing development of the therapist

- Explore your attitudes, prejudices and stereotypes to the many groups who are 'different'. Where did these perceptions come from? How operational are they now in your cultural life? How might these preconceptions manifest themselves in therapy with 'diverse' clients?
- Consult appropriate identity development models to aid your own awareness of where you might situate yourself and your development in relation to those in other groups.
- Strive to enhance your knowledge of current thinking in relation to diversities, and modify your skills and language appropriately.
- Monitor your humour and throwaway lines, your assumptions and your critical opinions. Important learning may be gained through self-reflection about your attitudes or your acculturation in these areas.
- Normative, general information about groups may be generally helpful, but be guided by Jung's dictum: 'Learn your theories as well as you can, but leave them aside when it comes to meeting the miracle of the living soul' (Jung, Baynes, & Baynes, 1928).
- In your training and in practice, systematically reflect upon the various facets of your identities (colour, ethnicity, class, ability, gender, sexual preference, age, etc.) and strive to understand these, particularly in relation to others who are different and diverse.
- 'Identity is always multiple, always complex, frequently conflicted and always changing' (Kettle, 2004, p. 24). Remember that neither the client nor you are only the identities you consider yourselves to be or the identities others perceive you to be. Identity is always more than you may perceive or intuit it to be. The client cannot and should not be reduced to their visible identity.

- Use supervision and therapy extensively to explore your attitudes and therapeutic relationships with different and diverse clients.
- Actively seek to work with therapists and supervisors from 'different' groups.

Consider the overall context within which you work

Does your agency embody principles of equal opportunity?

- Is your office easily accessible for those without private transport and for those who have mobility difficulties?
- Do you have appropriate access and toilet facilities for all clients?
- Does your agency work with a cross-section of clients that is similar to the cross-section of the local population you serve? If not, why not? What could be done about it?
- Is the internal environment of your agency sensitive and conducive to clients from 'diverse' origins?
- Does your agency employ different communication forms to work with different and diverse clients? This may include the use of interpreters, written materials in other languages, signers, texting, telephones and other electronic forms to enhance communication, hearing loops and so on.
- Encourage your colleagues to regularly discuss the challenges presented by different and diverse clients.
- Support and encourage the training of therapists from different and diverse groups.
- Strive to understand where you are socially situated, and how others may believe you are situated, in relation to personal power, role power and 'societal' (reference group) power.

We are only too aware, in writing much of this chapter, how apparently simple some of the suggestions and recommendations in the above sections may seem. However, it is our experience that each of these hypotheses for increased awareness and enhanced practice in relation to difference and diversity may expose therapists to pain, discomfort, shame and guilt. Considerable commitment to the notion of antioppressive/antidiscriminatory practice will be required for therapists to continue in their learning about themselves, about others and about society's multiple discriminatory practices.

The profound and far-reaching contributions made by Rogers and his colleagues to the theory and practice of person-centred therapy cannot be underestimated. Roger's ideographic stance – a deeply respectful, attentive, understanding-seeking approach – serves as a profound theoretical and clinical platform upon which to base one's professional practice as a therapist. But when it comes to working with 'diverse' and 'different' clients, additional knowledge, attitudes and skills are required.

Trainers of (person-centred) therapists are strongly urged to fully incorporate the issues of social context and diversity into their training programmes because, in this contemporary milieu, we know and experience that 'the world (in the shape of our clients) can and does come into our interviewing room' (Lago, 2011, p. 5).

Points for reflection

- When thinking about 'difference and diversity', what particular identities of clients or client stories do you find most challenging?
- What knowledge, skills and awareness would you require to work more skilfully and comfortably with such clients?
- Using the ethnic identity development models as a template for continuing professional development, where are you situated on these and what experiences or training might assist your further development?
- In commencing work with new client groups, what 'culture-specific' information would it be useful to have in order to work more sensitively and appropriately?

Key readings

- Alleyne, A. (2011). Overcoming racism, discrimination and oppression in psychotherapy. In C. Lago (Ed.), *The handbook of transcultural counselling and psychotherapy* (pp. 117–29) . Maidenhead: Open University/McGraw Hill.

Contains a very resourceful list of recommended practices for counsellors working within the different fields of diversity.

- Casse, P. (1981). *Training for the cross cultural mind*. Washington, DC: Society for Intercultural Education, Training and Research.

A dated but extremely useful resource containing a wide variety of training exercises exploring cultural differences, with background rationale, detailed exercises and training tips.

- Galway, J. (1991). *Immigrant settlement counselling: A training guide*. Ontario, CA: Ontario Council of Agencies Serving Immigrants.

This text also offers full training exercises with reference, specifically, to immigrant settlement processes, but many of the exercises might be modified to suit other circumstances.

- Katz, J. H. (1982). *White awareness: Handbook for anti-racism training*. Norman, OK: University of Oklahoma Press.

This is a dated, albeit classic, text, providing a wide range of training exercises geared to enhancing awareness of whiteness/majority identity in society.

- Kivel, P. (2002). *Uprooting racism: How white people can work for racial justice*. Gabriola Island, CA: New Society.

A more recent text (than Katz above) that contains different, but equally useful training resource ideas.

■ Lago, C., & Smith, B. (2010). *Anti-discriminatory practice in counselling and psychotherapy*. London: Sage.

This second edition of Lago and Smith's book now incorporates 15 chapters dedicated to the exploration of counselling people of diverse identities, including those of different ethnicity and class, issues of racism, working with women, children, older people and refugees, sexualities, sexual identities and gender, disfigurement and other visible differences, serious mental distress, religious difference, disability and multiple identities.

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30 Supervision

ELKE LAMBERS

This chapter discusses:

- The historical development of person-centred perspectives on supervision
- The nature and importance of the supervision relationship
- The focus in supervision on the counsellor's ability to relate congruently and in depth to clients
- Working with the counsellor's developmental agenda in supervision

Supervision as a professional activity: generic models of supervision

Most person-centred counsellors have experience of being in supervision. For many, supervision is a compulsory requirement only during training, but in some countries counsellors are required to have supervision throughout their working life as an ethical requirement and as a condition for professional accreditation or legal registration. In the USA, for example, supervision is an integral element of counselling training programmes, but there is no formal requirement for ongoing supervision after the training period; in Austria, where counselling and psychotherapy are regulated, being in continuing supervision is a legal requirement for registration. In the UK, therapists who are members of national counselling and psychotherapy associations are required to have regular supervision while practising, and practising without supervision is considered to be unethical.

Much of the literature and research about supervision for counselling and psychotherapy is written from a generic perspective, seeking to define the purpose, function and practice of supervision in terms of models that are applicable to supervision across different therapeutic orientations (Hawkins & Shohet, 2006; Henderson, 2009; Inskipp

& Proctor, 1993). There is an emphasis on developing an overarching framework for understanding and describing the supervision process and the supervision relationship, encouraging a movement away from 'approach-specific' supervision, which would only be of use to the 'purist' therapist (Page & Wosket, 2001, p. 31). Carroll (1996) suggests that supervision requires a theoretical understanding in its own right and that supervision demands skills different from those of counselling. He wants to:

> move individuals away from counselling bound models of supervision (that is, in which supervision is closely allied to the counselling orientation of the supervisor) to developmental and social role models of supervision (which start with the learning situation of the supervisee. (p. 4)

While the generic literature on supervision generally accepts the importance of supervision for self-development and as support for the therapist, the primary focus is on the work with the client, 'to maintain adequate standards of counselling' (British Association for Counselling and Psychotherapy, 2002, p. 1) or to 'enhance the therapeutic value of the counselling process' (Page & Wosket, 2001, p. 41). The growth of the therapeutic competence of the supervisee is the secondary purpose (Page & Wosket, 2001). The supervisor has a responsibility to monitor the work of the supervisee, and Carroll goes even further when he states that the client should be 'at the centre of supervision' and that 'counselling bound models of supervision can often stress aspects of the counselling work that ignore the client and concentrate on what is happening to the supervisee' (Carroll, 1996, p. 42).

Perspectives on person-centred supervision

A central feature in all writing about supervision from a person-centred perspective is the focus on the *experience of the therapist* and on the development of the therapeutic ability of the supervisee through the *supervision relationship*. In contrast to the generic approaches, there is a strong emphasis on the importance of congruence between the theoretical orientation of supervisor and supervisee (Hackney & Goodyear, 1984; Schmid, 1997). 'The supervisor needs to be aware of the person-centred approach at practical and theoretical depth' (Mearns, 1997, p. 84) or, as Patterson states even more strongly: 'supervisor and supervisee need to be committed to the same theory' (Patterson, 1983, p. 21). In order to support in the supervisee the development and integration of the therapeutic qualities of empathy, acceptance and congruence, these same qualities need to be present in the supervision relationship.

In that sense, supervision provides a model for supervisees' practice: not by teaching them the supervisor's way of doing therapy but, consistent with the theory of person-centred therapy, by offering a 'growth promoting environment that will enable the supervisee to find his or her own style' (Villas-Boas Bowen, 1986, p. 296). Villas-Boas Bowen distinguishes this approach to supervision, which puts an emphasis on the development of the supervisee's locus of evaluation, from 'form-oriented supervision', in which the supervisor has a commitment to a particular form of

person-centred therapy and discourages styles of expression that do not fit that model. Such an approach, in its concern with the preservation of a 'pure form' of person-centred therapy, is fundamentally inconsistent with a basic philosophical principle of the person-centred approach: the trust in the capacity for self-direction and self-determination (p. 293).

Historical development

Much of the early writing on person-centred supervision, particularly in the USA, centred on supervision with trainee therapists and students (Patterson, 1964, 1983; Rice, 1980; Rogers, 1942, 1951). The supervisor frequently also takes the role of trainer, and the challenge for the person-centred supervisor is to integrate in the supervision relationship developmental, facilitative elements with teaching and evaluative responsibilities.

Rogers (1951) was very aware of the importance of supervision; it was an integral part of his work with students. Writing about the training of therapists, he states that by providing the supervisee with an accepting, empathic and genuine atmosphere, the supervisor creates a climate in which the supervisee can explore feelings, blocks and difficulties that come up while learning to be a therapist (Rogers, 1951). Rogers' focus in supervision is firmly on the supervisee: 'to help the therapist grow in self-confidence and to grow in understanding of himself or herself, and to grow in understanding of the therapeutic process' (Hackney & Goodyear, 1984, p. 283).

Patterson takes a similar view: emphasizing the importance of the basic conditions of empathic understanding, respect, genuineness and concreteness in the supervision relationship; his view of supervision is that it is concerned with the 'development of sensitivity in the student, of understanding of therapeutic attitudes' (Patterson, 1983, p. 25). He describes supervision as being concerned with the 'actual relationship between the supervisee and the client, and not concerned with diagnosis or conceptualization of the internal dynamics of the client' (p. 24). His focus is on the experience of the supervisee, rather than on technique or on the learning of specific responses to clients.

Rice (1980) also writes about supervision in the context of training therapists. She conceptualizes the supervision process as a balance between supporting the supervisee's experience in the genuine human relationship with the client *and* supporting their understanding of therapy as a process that can be learned. She distinguishes two groups of attitudes, related to the therapist's ability to implement the client-centred conditions, that can be worked with in supervision: attitudes about human nature and the nature of change, and attitudes towards self (in the therapist). However, her emphasis appears to be slightly different from that of Rogers and Patterson. As one of the founding theorists of the process-experiential approach, her focus is more on the theory of the client's process and on the therapist's style of participation in that process (Rice, 1980), and less on the supervisee's self-experience in the relationship with the client or on the relationship in supervision.

A focus on supervision with trainee therapists is also at the core of Barrett-Lennard's overview of person-centred writing on supervision (Barrett-Lennard, 1998). He too attempts to capture the essence of supervision when he describes it as 'growth-learning' (p. 333), supporting an 'evolution of consciousness, not only in respect to self, but in span of receptivity toward the experiencing of others' (p. 336). As one of Rogers' ex-students, and with first-hand experience of supervision with him, he describes Rogers' movement from a evaluative, guiding style of supervision in the early 1940s to the much more student-centred and facilitative style after 1951 (p. 325).

More recent writing on person-centred supervision continues to explore the nature of the supervision relationship, the relevance and applicability of the core conditions in supervision, and the purpose of supervision not only for trainees, but also as part of the ongoing development of the therapist. Lambers (2000, p. 196) defines supervision as 'facilitating congruence'. She explores the meaning of the therapeutic core conditions in the supervision relationship, and looks at the challenge for person-centred supervision in the context of current professional and ethical thinking. The theme of developing the therapist's congruence is also present in the writing of Schmid, who extends the concept of 'encounter' to the meeting in supervision (Schmid, 1997).

Merry integrates the core conditions in his concept of supervision as a process of 'collaborative enquiry': 'an open, empathic and non-judgemental environment that is simultaneously questioning and supportive, promoting congruence and an internal locus of evaluation in the supervisee' (Merry, 2001, p. 183; see also Bryant-Jefferies, 2005; Merry, 1999). His concept of supervision as a kind of 'personal research project' (Merry, 2004, p. 193) fits well with the spirit of Rogers' view of person-centred therapy as a process of testing the central hypothesis of the approach.

In the first book completely focused on person-centred supervision, Tudor and Worrall (2004) developed a theory of person-centred supervision based on Rogers' theory of therapy and personality change. As well as exploring the relevance of the six core conditions in supervision, they applied Rogers' process conception of psychotherapy (Rogers, 1967) to the process of development in the supervisee. Through the experience of being fully received in the supervision relationship, supervisees are enabled to become more fluid and open to both their own and their clients' experiences, and to communicate more openly and freely. Worrall further defines empathy as a central dimension in the therapeutic process, and therefore the primary task of supervision is 'facilitating the supervisee's capacity to offer empathic understanding' (Worrall, 2001, p. 206). The supervisor's congruent empathic stance in relation to the supervisee in turn fosters the supervisee's ability for congruent empathic understanding of the client.

An experiential perspective is represented by Baljon (2002), illustrating how supervision can be used to 'teach congruence' to supervisees, using Gendlin's (1981) focusing concepts. Madison (2004) also explores how attending to supervisees' experiential process can help them to develop their reflective ability and to become more deeply in touch with their responses and reactions in relation to the client.

The relationship in supervision

The dynamic of the supervision relationship is a relatively unexplored area. The term 'supervision' is in itself sometimes criticized as having implications of 'control' and 'overseeing', implying a power imbalance and authority relationship that is fundamentally incompatible with the philosophy of relationship in the person-centred approach. Mearns acknowledges the importance of being aware of the 'unspoken relationship' between supervisor and supervisee, and the need for a commitment to make time to examine the unspoken norms and expectations that may have developed in the relationship (Mearns, 1991). He defines a 'healthy supervision relationship' as one characterized by the supervisor's commitment, congruence, empathy and consistent valuing of the supervisee. In such a relationship, the supervisor can be a 'supportive challenger' – someone who will offer the challenge of another perspective, but in a context where the supervisee feels respected, both personally and professionally.

This theme of challenge is explored in some detail by Kilborn. Her study shows that challenge in a trusting supervision relationship can be experienced as stimulating and valuing (Kilborn, 1999). A similar positive welcome to challenges is found in the work of Auckenthaler, a German psychotherapist, who sees supervision as a place for critical exploration and dialogue in a supportive relationship. The combination of a critical and 'benevolent' attitude creates an 'error-friendly' (*fehlerfreundliche*) context in which both supervisor and supervisee can acknowledge errors, welcome their exploration, take responsibility and learn from them (Auckenthaler, 1995 p. 156).

Relatively little is written about the direct experience of the supervision relationship, either from the perspective of the supervisor or from that of the supervisee. Those new to supervision may be interested to hear the experience of students of person-centred therapy, in particular with developing an understanding of the purpose of supervision and managing the relationship dynamic in the supervision (Buchanan & Hughes, 1999). Moore (1991) and Gibson (2004) give an account of their experience as supervisees, each confirming the value of the experience of being deeply heard and being supported and encouraged to find their own style as therapists, and describing their experience of the core conditions in the supervision relationship.

A unique and courageous three-way perspective (supervisee, supervisor and client) is offered by Jacobs (1996). His experience illustrates powerfully how the therapist's greater awareness of himself, facilitated by the supervisor's attention to his experience in relation to the client, made it possible for both client and therapist to become more congruent with each other and to express some of their unspoken relationship.

Focus on the therapist's experience

A consistent theme in the above-mentioned literature is that the purpose of person-centred supervision is defined in terms of the development of the therapist's ability to be congruent, integrated and fully present in the therapeutic relationship. Central in supervision is the experience of the therapist and the reflection on the relationship

between client and therapist, rather than the exploration of a client 'case' (Lambers, 2000; Mearns, 1997; Patterson, 1983). Rogers writes about supervision as offering 'primarily a listening, facilitative understanding, helping the therapist to become clearly aware of their own feelings in the therapeutic sessions so he can be more adequately come to be himself in the relationship' (Rogers, 1957, p. 86). Particularly relevant in his view of supervision is Rogers' wish to avoid 'imitative modelling' (Villas-Boas Bowen, 1986, p. 296), guiding or coaching the supervisee to respond according to the supervisor's model (Rogers, 1957).

The supervision relationship offers a context where the therapist can bring into awareness experiences and processes emerging in her in the relationship with the client, and where she can explore the relationship qualities necessary for her therapeutic work. She may explore a wide range of experiences: strong feelings of attraction or repulsion, sadness, anger, powerlessness, love, fear, or hopelessness. She may bring barely symbolized sensations, on the edge of her awareness – a shivery feeling, a whiff of dread, a sensation of tiredness. She may bring experiences that she is familiar with, but equally she may discover something completely new in the course of the supervision session. In this view of supervision, the supervisor's intention is to facilitate and support the development of the therapist's ability to be open to her experience, to be fully engaged and present with her clients, and of her ability to relate at depth.

However, this does not mean that the focus in supervision is exclusively on the therapist's feelings. There is a common misconception that person-centred work favours a focus on the exploration of feeling and on relating in the affective realm of experience (Lambers, 2000). The imposition of such a narrow focus, both in therapy and in supervision, may in effect create a condition of worth: 'to be accepted I must talk about feelings, or even better, *show* feelings'. Relating to the 'whole person' involves relating to the person in all aspects of their experience and their existence. In supervision, 'focusing on the supervisee's experience' means being open to affective, cognitive, physical and spiritual dimensions, as well as to the exploration of professional and ethical questions.

Box 30.1 outlines some of the possible topics that can be worked with in supervision, and a variety of methods can be used to support such explorations. Personal dialogue and theoretical discussion, the therapist's reflective notes or diary, role-play, audio- or videotapes of sessions with clients all bring variety and creativity into the sessions. Supervisees may also find it useful to develop a checklist of questions that can assist them in their reflection (Mearns, 1997).

In the early writing on supervision, frequent reference is made to the use of tapes of actual counselling sessions – a practice pioneered by Rogers in the early 1940s that has continued to today (Mearns, 1997). Rogers (1942) writes with enthusiasm about learning through listening, together with students and colleagues, to recordings of therapy sessions, and, consistent with her approach to supervision, Rice (1980) uses taped material to facilitate reflection on the therapy process. Patterson (1983) describes the use of tapes both for teaching purposes (in group settings) and in individual sessions, to facilitate reflection on the supervisee's experience.

Box 30.1

An illustration of the breadth of focus in supervision

A supervision session may consist of some (or all) of the following:

- Encouraging reflection and expression of the therapist's experience in relation to clients
- Exploring understanding of the client's perspective and experience of the therapy relationship, and the unspoken relationship
- Exploring the therapist's presence, congruence and relational depth
- Integrating the therapeutic conditions in the therapist
- Thinking about different ways of responding to the client
- Listening to an audiotape or watching a videotape of a therapy session
- Exploring theoretical understanding in support of the work with a specific client
- Understanding the client in the context of their culture, with an awareness of the impact of cultural difference on the therapy relationship
- The challenge of working with clients who are very different from the therapist
- Understanding 'difficult client process'
- Professional issues – ethical frameworks, multidisciplinary teamwork, communication with other professionals
- Reflecting on the social context of therapy
- Attention to the 'self' of the therapist: personal development, competence, current functioning, workload
- Impact of current life events on the therapist's relationship with clients
- Acknowledging and exploring stress, burn-out and fitness to practise
- Identifying needs for training and development of the therapist
- New writing in person-centred approaches that are relevant to the therapist's work
- The unspoken relationship and power dynamic in the supervision relationship
- Ending with a client; the impact of holidays and breaks in therapy
- Learning from a conference or training event
- Plans for research
- Exploring ways of 'expanding imagination'

Bringing the actual interaction between client and therapist into the supervision session has many benefits. It allows the therapist to relive their experience, offers opportunities for systematic exploration of the process of a session and is the only way in which the client, and the therapist's interaction with the client, can be directly represented in the supervision session (Mearns, 1997).

Responsibility and ethics

Working so closely with the therapist's experience and process, and sometimes on the powerfully felt edge of the experience of humanity, the person-centred approach to supervision is sometimes accused of mainly reinforcing a theoretical tradition even worse, of being unethical through its focus on the supervisee 'at the expense of client welfare' (Lawton & Feltham, 2000, p. 9; see also Davenport, 1992). Underlying this judgement is, as well as a profound misunderstanding of person-centred practice, a view that supervision should and *can* ensure the welfare of the client, and that this should be done through assessment and evaluation of the supervisee's therapeutic ability, through monitoring of their practice and through clinical discussion of the client's diagnosis, motives and needs.

Therapeutic practice can be viewed from two perspectives: from inside the approach of the therapist, and from outside, representing a societal or professional perspective. The outside perspective represents the frame of reference of the profession, of society and of the culture in which the therapist and supervisor operate. This view represents a moral and legal view of the activity of therapy, and defines ethics in term of moral and legal standards. Therapists from all orientations have a responsibility to work within this framework. The person-centred supervisor aims to offer a context in which both frameworks are present and can be explored, and where the supervisee can evaluate her practice from both the perspective of professional ethics and that of her understanding of person-centred therapy.

Within the perspective of person-centred therapy, ethical practice is to maintain a consistent offer of authentic relating to the Other (Schmid, 2001), based on an attitude of deep respect for the uniqueness and psychological freedom of the other person (Grant, 2004). When there are specific concerns about the supervisee's practice from this ethical person-centred perspective, the challenge to the supervisor is to offer a consistent, accepting relationship through which the supervisee can explore their functioning as a therapist and move towards greater congruence and authenticity in relation to the client. In doing so, the supervisor acts ethically and supports the supervisee to act ethically:

> the supervisor who is able to see from both perspectives, who can function confidently within both frameworks and who offers the supervisee congruent acceptance creates in the supervision relationship an excellent basis for support, challenge and for open, respectful exploration and dialogue about both therapeutic and ethical issues. (Lambers, 2000, p. 210)

Relationship qualities in supervision: the meaning of the core conditions

It would seem obvious that, in order to make it possible for the therapist to explore the depth of her experience with the client, the supervisor in turn needs to be prepared to offer a high level of engagement and presence in the relationship with the super-

visee. As in therapy, empathy, acceptance and congruence are important relationship qualities, supporting and facilitating a climate of mutual trust and respect. In supervision, these qualities help to create a relationship where supervisor and supervisee can work together creatively towards a genuine dialogue, in a spirit of 'collaborative enquiry' (Merry, 2001). In such a climate, the supervisee is secure and free to give expression to thoughts, feelings and concerns that are in her awareness, to focus on not yet symbolized experiences in relation to her clients, or to bring questions and issues related to external factors that have an impact on the therapy relationship.

The supervisor's *empathic presence* facilitates the supervisee's process of 'tuning in' to whatever is around in her experiential process. Supervisees sometimes have only a vague sense of what is going on for them – there may be just a feeling of something on the edge of awareness. On such occasions, a 'focusing' response, making space for the experience, may be particularly helpful. As mentioned earlier in this chapter, empathy should be extended to all of the supervisee's experiences and concerns, and not only to emotions.

The supervisor's acceptance, the willingness to respect and value the supervisee as a person of worth, communicates trust in the supervisee to find their own unique way of relating to their client. The experience of the supervisor's *acceptance* may enable the supervisee to allow into awareness experiences that are unacceptable or a threat to their self-concept (both personal and/or as a therapist) and may offer support towards a greater openness in their exploration of the therapeutic relationship.

Supervision is not about monitoring or assessing practice, nor is it about ensuring that the supervisee works in a recognized, approved 'person-centred' way. The function of supervision is to support the supervisee in 'finding her or his own style of being a therapist' (Villas-Boas Bowen, 1986, p. 293). Against the background of this non-judgemental position, the supervisor's contribution to the supervisee's exploration can be experienced as challenging, but nonetheless as 'stimulating and enriching' (Kilborn, 1999, p. 89). This challenge does not come from criticism, authority or judgement, but from a congruent, consistent acceptance that invites supervisees to enter into an open, non-defensive reflection and to take responsibility for their own congruent self-exploration.

Congruence is an essential condition in the supervision relationship. To acknowledge fully the experience of being, or striving to be, in relationship with a client may leave the supervisee feeling exposed and vulnerable. In those moments, there may be a conflict between the wish to be open to experience, and the need for self-protection, and the supervisee may struggle with being congruent. The supervisor's full engagement with the process of the supervisee is only possible if she is open to her own experience – congruent expression of empathy and acceptance give depth and meaning to the relationship. It helps the supervisee to become more present and congruent; it also provides a model for their own practice (Lambers, 2000). Transparent self-reflection and communication are important ingredients in the development of a collaborative relationship in supervision. Congruence in the supervisor facilitates self-reflection in supervisees and strengthens their internal locus of

evaluation (Merry, 2001). In Box 30.2, the extract from a supervision session illustrates how the supervisor's congruent engagement in the relationship with the supervisee facilitates self-reflection.

Box 30.2

Facilitating the supervisee's self-reflection

Kate: I need to talk about this new client. I have seen her only once. I am not sure what to make of her. I felt she was checking me out; she said she had read a lot about therapy and was thinking about going on a training course. She was critical of person-centred therapy – said she did not want someone who was just going to repeat everything she said. I thought she was quite hostile.

Supervisor: That sounds like it was a difficult start for you and it left you feeling unsure and uncomfortable.

K: [*in an irritated voice*] Well, of course! She was sarcastic and aggressive. I think she wanted me to get angry at her – like she was testing me.

S: [*short pause*] I feel a bit taken aback right now. You sound angry. I wonder if I got it wrong when I said you seemed unsure and uncomfortable …

K: [*short pause*] I really had a hard time with my client – I felt attacked, and a bit intimidated. I don't know if I can work with her. I felt quite upset.

S: Yes, that sounds much worse than unsure and uncomfortable … Are you also upset with me?

K: I was for a moment. I felt that you did not understand how difficult that session had been. And I was upset about what my client said – but to be honest, I felt bad about myself too. I don't think I did a very good job – I was pretending to listen to her but I was really false. I just became defensive. We made another appointment but I wonder if she will come back … it can't have been a good experience for her. What do you think I should do when she comes back – if she comes back?

S: I understand you are anxious about the next session and of course, we will talk about it. But before we do that, how would it be if we talked a bit more about what happened to you in that first session?

K: Yes, you are right. I need to think more about what was going on for me, why I became so defensive. Then I can think about the next session … I do hope she will come back …

Supervision or therapy?

All approaches to counselling and psychotherapy subscribe to the view that it is important for therapists to be open to personal exploration of unresolved issues, arising either out of their past or current life experiences or in the relationship with a client, which may constitute 'blocks' or 'blind spots' in the therapeutic relationship or interfere with the therapeutic process. Supervision offers an opportunity to bring such vulnerabilities and unresolved issues into awareness, to consider their impact on the therapist's functioning and on the therapy relationship, and to reflect on the best course of action (Lambers, 1993). Because of the emphasis on the relationship and on the therapist's self-development, person-centred supervision is sometimes viewed with some suspicion, as though it confuses therapy with supervision. In fact, in most of the above-mentioned writing, some space is given to the discussion of the difference between supervision and therapy, and without exception, all agree that while supervision can touch deeply personal aspects of the supervisee's experience, supervision is not therapy – although it can be therapeutic (Hackney & Goodyear, 1984; Mearns, 1997; Patterson, 1964, 1983; Rice, 1980).

The supervision relationship can be conceptualized as parallel to the therapy relationship, but there is an important difference in focus: in therapy the client has absolute freedom to talk about any aspect of their experience, but in supervision the primary focus is on the therapist's experience as it emerges in the relationship with the client (Patterson, 1964; Villas-Boas Bowen, 1986). It is important that supervisor and supervisee remain clear about the purpose of the supervision relationship, particularly when issues emerge (either in the relationship with the client or in the supervision relationship) that expose important areas of conflict or unresolved personal issues, problematic patterns of relating or vulnerability. Some exploration of such difficulties in supervision may be necessary and indeed of great value, but both need to take responsibility for maintaining and managing the boundaries of the relationship, and it may be necessary to consider other arenas for the exploration of severe or persistent difficulties.

The supervisor too may experience personal challenge or discover areas for personal learning through the relationship with the supervisee, both through the in-the-moment relationship in supervision and through the shared exploration of therapeutic work. Many supervisors, myself included, report that they find working as a supervisor of enormous benefit to their therapy work, as well as to their own personal and professional development

The developmental agenda in supervision

In current thinking about person-centred therapy, increasing emphasis is placed on the *centrality of the relationship*. Mearns describes the importance of relationship in person-centred therapy as follows:

> not just 'relationship' at the superficial level of the 'therapeutic alliance' – my emphasis is on the creation of a particular depth of relationship between client

> and therapist – a depth of relationship which allows the client to feel an extraordinary safety, such that they can go to particular depths within their own experiencing. (Mearns, 2005)

The challenge for the person-centred therapist is to become able to offer that depth of relating *to every client*. This is the therapist's ongoing 'developmental agenda' (Mearns & Cooper, 2005).

Initial training provides a supportive environment in which the therapist can experience and explore the limits of their acceptance and understanding. After training, learning to expand and stretch one's capacity to engage deeply with an ever-increasing variety of people – and with a greater depth of experiencing – remains one of the most challenging aspects of the life-long developmental process of every therapist.

Supervision is often the only place where therapists can share their experience, reflect on their work and on the impact it has on them, and attend to personal challenges as well as professional and ethical concerns. The primary focus in a supervision session is usually on the exploration of issues directly arising from ongoing therapy practice, and not much time is left for taking a wider overview of their deeper significance and meaning for the therapist's development (Lambers, 2012). However, supervision could provide an excellent context for focused and *explicit* attention to the therapist's 'ongoing self-curriculum' (Mearns & Cooper, 2005, p. 155). The supervisor then becomes a sounding board or, even better, an active partner in the therapist's process of setting out, monitoring, developing and updating their developmental agenda.

'Relational therapy is best supported by relational supervision' (Lambers, 2006, p. 274). Supporting the supervisee in the development of their ability to relate at depth, being fully open to the experience of being authentically present (Schmid, 2001) in the relationship with clients, requires a high degree of presence and authenticity on the part of the supervisor. Such a relationship offers the supervisee the freedom to engage with their experience, and allows them to define and pursue their own developmental agenda, without the supervisor dictating how they practise or what they should attend to in their self-development (Lambers, 2006). As stated so succinctly by Villas-Boas Bowen: 'the function of the supervisor is to create the atmosphere that will enable the supervisee to find his or her own style of being a therapist' (Villas-Boas Bowen, 1986, p. 296). Or simply, in the words of one supervisee:

> I know you were sometimes worried about me, but you let me get on with it.

Conclusion

Person-centred supervision is firmly rooted in a potentiality model: the supervisor accepts the supervisee as a person in process and trusts their potential for growth and development (Lambers, 2000). The purpose of person-centred supervision is to facilitate the counsellor's congruence and their ability to relate at depth through reflection on the counsellor's experience of *self* in the relationship with clients. Trust, respect, acceptance, empathy and congruence are essential aspects of a collaborative supervi-

sion relationship. The development of the ability to meet every client at depth is part of the ongoing developmental agenda of the therapist, and the supervision relationship is an excellent context for attending to this agenda.

Points for reflection

- What is important to me in supervision?
- How do I work as a supervisor?
- What do I need to work on in my development so that I can offer an encounter at relational depth to every client?
- How can I use my supervision to explore my developmental agenda?

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31 Research

ROBERT ELLIOTT

This chapter discusses:

- What positivist outcome research tells us about person-centred experiential therapy
- The anatomy of a number: a deconstruction of positivist therapy research
- Mixed-method person-centred experiential therapy research
- Promising possibilities for person-centred experiential therapy research

Is person-centred experiential (PCE) research possible? In the early 1960s, Carl Rogers gave up both academia and the practice of scientific research, and spent the rest of his life engaging in action-oriented pursuits. In retrospect, some (see, for example, Lietaer, 1990) have argued that this was a mistake of historical proportions, and accounts in large part for the current beleaguered status of person-centred therapy. Regardless of this, some time about 1990, PCE therapists woke up to the fact that they were being systematically and progressively excluded from training and healthcare venues throughout the world and needed to do something. Re-engaging in research was put forward as a key proposed solution, especially by those working in Europe or in the experiential part of the tradition (see, for example, Elliott, 2002; Greenberg, Elliott, & Lietaer, 1994; Lietaer, 1990; Sachse, 2004). In fact, a veritable profusion of research on person-centred and closely related therapies has occurred over the past 20 years, paralleled by the rapid emergence and acceptance of qualitative research during the same time period.

However, in this rush forward, the issue of the consistency of the emerging research literature with PCE principles has often been overlooked. Much of the recent spate of research has been quantitative and positivistic in nature (that is, based on assumptions of objectivity and the search for definitive knowledge); in some cases,

it has used randomized clinical trial (RCT) designs, typically viewed as the epitome of rigid scientism by person-centred followers, postmodernists and humanists in general (Bohart, O'Hara, & Leitner, 1998). In fact, the body of so-called positivistic therapy research has been surprisingly supportive of person-centred and related approaches in spite of the deck being stacked against them in multiple ways.

Nevertheless, the ethical-philosophical issue remains: is it acceptable for political purposes to make use of research whose principles are antithetical to PCE therapy in order to fend off unfair attacks? More fundamentally, what is it about positivist research that might be anti-person-centred? Is a science based on PCE principles possible? And, if so, what might it look like? These are some of the questions I will try to answer in this chapter.

What does positivist outcome research tell us about PCE therapy?

Ironically, systematic, quantitative outcome research has a person-centred pedigree: the first controlled study of the outcome of psychotherapy was reported by Rogers and Dymond (1954), although the features of modern RCT design – psychiatric diagnosis, standardized symptom measures, placebo control groups, treatment manuals, complex statistical analyses – evolved later. (By contrast, the Rogers and Dymond study relied heavily on individualized and projective measures, used a general outpatient sample, was not completely randomized and used primitive statistics.)

General effects of humanistic/experiential therapies

Over the past 50 or more years, PCE therapies have been the subject of almost 200 studies reporting pre-to-post-therapy results, including some 60 controlled studies comparing one of these therapies with the results in an untreated control group, and 100 studies comparing one of these therapies with some other kind of therapy (Elliott & Freire, 2010; Elliott, Watson, Greenberg, Timulak, & Freire, in press). My colleagues and I have used meta-analytic methods to statistically combine the results of these studies, from which the following conclusions can be drawn (Elliott et al., in press; Elliott, Greenberg, & Lietaer, 2003):

- Clients who participate in PCE therapies show large amounts of change over time, with an average effect size (ES) of about 1.0 standard deviation (SD) unit, which is considered by social scientists to be a very large effect, many times larger than the effects typically found for common medical procedures or medications. In other words, on average, PCE therapies make a big difference to clients. Furthermore, this is particularly true for general symptom measures.
- Post-therapy gains in PCE therapies are stable: they are maintained over early and late follow-up periods. This stability of post-therapy benefit is consistent with the PCE philosophy of enhancing clients' self-determination and empowerment, indicating that clients continue to develop on their own after they have left therapy.

- In controlled studies, clients who participate in PCE therapies typically show substantially greater change than comparable untreated clients (mean difference about 0.8 SD). These studies show that there is a causal relationship between PCE therapy and client change; in person-centred terms, we can say that clients use PCE therapies to cause themselves to change. In roughly half of the studies, clients were assigned randomly to therapy versus no therapy (or a waiting list), making these 'randomized clinical trials' and providing a stronger level of evidence (mean difference also about 0.8 SD).
- In studies comparing active treatments, clients undergoing PCE therapies show gains that are equivalent to those of clients seen in the other therapies (the mean overall difference in pre-to-post ESs between the groups was about 0.0 SD, with the same value for both randomized and non-randomized studies).
- On the other hand, PCE therapies might be trivially worse than cognitive-behavioural therapy (CBT): when the whole sample of PCE therapies in our meta-analysis was compared with CBT, there was a small but statistically significant advantage in favour of CBT (mean difference about 0.2 SD).
- However, when clients seen in 'pure' person-centred therapy were compared with clients seen in CBT, the results were equivalent (a mean difference of –0.09 SD, with the same value for both randomized and non-randomized studies).
- Interestingly, PCE therapies labelled by researchers as either 'supportive' or 'non-directive' did less well than CBT (–0.35 SD). In most cases, these were studies carried out by CBT researchers using non bona fide versions of PCE therapy, the clients being explicitly labelled as 'controls'. This appears to be the source of the small apparent general advantage for CBT over PCE therapies.

Effects of person-centred therapy

Let us take a look at the subsample of pure person-centred therapy studies, that is, studies emphasizing therapist facilitative conditions without additions to or limitations on that. As Table 31.1 indicates, the results of a more focused analysis of the 65 studies of pure person-centred therapy are generally highly comparable to those reported for the larger meta-analysis. First, the overall pre-to-post effect is also quite large and of the same order (mean ES 0.97). Second, the effects are similar across time, from immediately after therapy (mean ES 0.97) through early follow-up (less than a year; mean ES 0.91), to late follow-up (a year or longer; mean ES 1.02). Third, in 20 studies comparing person-centred therapy clients with clients receiving no treatment, the effects were again large and comparable to those of the larger study (mean difference in pre-to-post ES between the treated and untreated groups 0.69). Fourth, in 43 studies comparing clients seen in person-centred therapy with clients receiving non-PCE therapies, there was essentially no difference – a mean difference in pre-to-post ES of 0.02. This value is close enough to zero to indicate that person-centred therapy is equivalent in effectiveness to non-PCE therapies.

Table 31.1 Summary of overall pre-to-post change and controlled and comparative ESs for person-centred therapy (PCT) outcome studies

	Number	Mean (ES)	SD (ES)
Pre-to-post ES (mean Hedges' g)			
By assessment point			
Post	58	0.97	0.62
Early follow-up (1–11 months)	22	0.91	0.68
Late follow-up (12+ months)	21	1.02	0.57
Overall	65	0.97	0.62
Controlled ES (versus untreated clients)			
Unweighted mean difference in ES	20	0.69	0.47
PCT mean pre-to-post ES	18	0.79	0.42
Control mean pre-to-post ES	18	0.08	0.18
Comparative ES versus non-PCE therapies			
Unweighted mean difference	43	0.02	0.38
PCT mean pre-to-post ES	43	0.99	0.62
Comparative treatment mean pre-to-post ES	43	0.97	0.61
Comparative ES for PCT versus CBT			
Unweighted mean difference	22	–0.09	0.29

Note: Unweighted Hedges' g used. Controlled and comparative ESs use average (mean) difference in pre-to-post ESs for conditions compared, except where these are unavailable (in which case post-tests were compared); positive values indicate results favouring person-centred therapy.

However, we are not yet done with the story because, in the current political situation, it is commonly believed that CBTs are more effective than person-centred therapy. For example, in the UK, the current National Institute for Health and Clinical Excellence guidelines for depression state that CBT should be offered first to clients, and then if they refuse, they can be told about person-centred counselling and also told that the evidence for its effectiveness is weak (National Collaborating Centre for Mental Health, 2009). It is therefore necessary to look more closely at the 22 studies involving direct comparisons between person-centred therapy and CBT. As Table 31.1 indicates, the average difference in amount of pre-to-post change in these studies is –0.09 SD, a very small effect in favour of CBT. This means that CBT *might* be very slightly more effective than person-centred therapy, but that this can be regarded as trivial for practical purposes. In other words, for any given situation, the characteristics of the client, therapist and their emerging relationship will vastly overshadow any almost undetectable difference.

Furthermore, the role of researcher allegiance has not yet been considered. This is the well-established finding that researchers comparing active therapies tend to find results that accord with their theoretical beliefs (see, for example, Luborsky et al., 1999). In the larger meta-analysis from which the person-centred therapy versus

CBT studies were drawn, there was a strong and statistically significant allegiance effect, in the form of a correlation of –0.49, indicating that researchers of either persuasion tended to find what they expected. Interestingly, in this sample of pure person-centred therapy studies, there was no researcher allegiance effect (the correlation being +0.16), probably because the so-called 'non-directive/supportive' therapy studies had been removed. This is fortunate because only one of the 22 person-centred therapy versus CBT studies was carried out by a supporter of person-centred therapy (Teusch, Böhme, & Gastpar, 1997), whereas 11 were carried out by advocates of CBT and 10 by neutral parties.

What this all means is that when people claim that CBT is more effective than humanistic therapies or counselling, they are not talking about person-centred therapy but rather a caricature in the form of so-called 'non-directive/supportive' therapies, which are typically rendered less effective by being restricted in terms of time or content and labelled as 'control' conditions. One obvious moral that might be drawn is that person-centred therapy researchers should do their own research in order to make sure that their approach is fairly represented!

Anatomy of a number: a deconstruction of positivist therapy research

In the previous section, I reported that the average difference in client change in person-centred therapy versus CBT was –0.09 in favour of CBT. But what does this number mean? Where does it come from? What does this have to do with the client's lived experience?

In positivist therapy research, it all starts with the client sitting down to fill out a standardized, quantitative psychological measurement instrument, such as the CORE Outcome Measure (CORE-OM), a widely used measure of client psychological distress (Barkham et al., 2001; see Box 31.1). From a positivist point of view, these responses are just observable behaviours that psychometric research has shown to be related to other responses on the same and different instruments. For example, the 'feeling alone' item tends across people to go up and down together with the rest of the items on the CORE OM ('interitem reliability'), and, in the absence of therapy, tends to be relatively consistent over a few weeks or a month ('test–retest reliability'). In other studies, it also correlates with other distress measures, like the Beck Depression Inventory (Beck, Steer, & Garbin, 1988; this is called 'convergent validity') and does not correlate too much with nuisance variables such as reading ability or a tendency to tell people what you think they want to hear ('discriminant validity'). In addition, the CORE-OM has high measure utility because it is easy to give to clients to complete on their own time and does not take long to score, thus being perfect for bureaucratic purposes. In addition, clients generally find it useful to complete because it helps them symbolize their experience and gives them a sense of having their progress tracked over the course of therapy ('clinical utility').

Box 31.1

Eilidh confronts the CORE-OM

Eilidh is a moderately depressed, 30-year-old estate agent in an RCT comparing person-centred therapy with CBT. At her meeting with the researcher before her first session, she is given a set of outcome questionnaires to complete, starting with a widely used measure of general psychological distress, the CORE-OM.

On the CORE-OM, she is asked to rate how often she has had each of a series of 34 troubling experiences over the past week, using a standard 5-point scale, ranging from 0 ('not at all') to 4 ('most or all of the time'). When she comes to the first item, 'I have felt terribly alone and isolated', she is asked to decide whether this description captures the quality of her depression, and how distressed by her feelings of loneliness and isolation she has felt over the past week. After considering briefly, she chooses 3 ('often'). She then goes on to rate the other 33 items.

In this study, there are three other outcome instruments, on which Eilidh is asked to rate her interpersonal difficulties (for example, she lets people push her around more than she likes), how she feels about herself (for example, she is critical and neglectful of herself), and how much in touch with her inner experiences she is (for example, she is generally focused on trying to please others and doesn't know what she is feeling). Finally, 4 months later, at the end of 16 sessions of person-centred counselling, Eilidh is asked to complete these same questionnaires again. Let's say that at this point she is feeling much better, so this second time she gives a 1 ('only occasionally') for feeling 'terribly alone and isolated'.

Because these conditions are reasonably met for the CORE-OM, researchers believe that they can confidently relate this item (along with others like it) to abstract psychological concepts such as psychological distress severity. Thus, going back our client in Box 31.1, Eilidh's ratings of all 34 items are averaged together before therapy, say, for a mean score of 1.89, which indicates a moderate level of clinical distress, and also at the end of therapy, say, for a mean score of 0.74, which indicates only minor or subclinical distress, amounting to what is considered to be a substantial and statistically reliable improvement (in this case, 1.15 units).

Next, the researcher averages together the pre- and post-therapy scores of the whole collection of depressed clients receiving person-centred therapy, and calculates a mean and SD for each set, obtaining, for example, a pre-therapy average (mean) of 1.77 (SD 0.39) and a corresponding post-therapy value of 0.98 (SD 0.61). In order to determine how much this amounts to, the researcher then finds the difference

between the pre- and post-therapy group means (here, 0.79) and converts this difference score into a common metric or ruler by dividing it by the 'pooled standard deviation' (a special kind of average of the two SDs, in this case, 0.51); the resulting value is referred to as a *pre-to-post ES* (here, 1.56 SD units, which is a very large value). The same process is followed for all four outcome measures, resulting in an average pre-to-post ES of, say, 1.13 SD units. (In our example, some of the other instruments, like the experiential processing measure, have much smaller effects than the CORE-OM.)

Because this is a comparative RCT conducted by an advocate of CBT, there is also another group of clients who have been given 16 sessions of CBT focused on depression. For a variety of reasons, these clients show slightly larger pre-to-post effects across the four outcome measures, say 1.22 SD. These reasons are likely to include the following: the therapists are a bit more closely supervised; the CBT therapists are slightly more comfortable working in a research context; some of their clients like the structure; and the therapists 'teach to the test', signalling implicitly to their clients how they are expected to respond at the post-therapy point. The comparative ES in our example is thus just slightly (but not significantly, at –0.09) in favour of CBT, the value reported earlier in the meta-analysis of person-centred therapy versus CBT.

But, again, what does this mean? A value of –0.09 is an extremely abstract number, from which all specific references, such as the characteristics of client and therapist or the way in which the PCE or other therapy was carried out, or even the type of outcome measure and so on, have been removed. In other words, all but the most general meaning has been stripped from this number. All we know is that the clients in the person-centred therapy experience about the same amount of improvement as the clients in CBT. This has almost nothing to do with Eilidh's lived-experience; her idiosyncratic inner valuing process is ignored, and there is no way of determining its authenticity. In other words, it fails the fundamental PCE principles of contact, empathy, acceptance and genuineness.

However, it is politically a very useful number, because it can be used to persuade professional bodies and government officials that PCE therapy is a valid and effective treatment, so that they will allow PCE therapy training to continue, and perhaps even mandate government health service provision or health insurance payment for it. So such numbers are valuable and probably even essential for PCE therapy to continue to survive. (This is an example of 'political validity'.) But there is nothing person-centred about this number; in fact, it fundamentally violates person-centredness. So what is to be done about the necessity of such numbers? If we remain ideologically pure, we risk passing out of existence, thus depriving clients of a unique way of working through their problems. But if we stop our search to understand client change in PCE therapy with these kinds of numbers and the ends-justify-the-means logic that go with them, then we will have totally sold out our clients and ourselves for a positivist golden calf. Surely we can do better than this.

Mixed-method PCE therapy research: render unto Caesar

It seems to me that there is really only one sensible way forward: to simultaneously carry out *both* political-positivist and person-centred research, to render politically expedient quantitative data to the government and professional bodies ('Caesar'), while at the same time carrying out (even in the same study) research that completely honours both our clients and our person-centred principles (Elliott, 2002).

Several writers, including Mearns and McLeod (1984) and Barrineau and Bozarth (1989), have spelled out what this kind of research looks like by applying basic person-centred principles to the conduct of therapy research:

- The PCE therapy researcher focuses on understanding, from the inside, the client's lived experiencing.
- The PCE therapy researcher accepts and even prizes the client's experiencing, and does not judge it.
- The PCE therapy researcher tries to be an authentic and equal partner with the client, treating the client as a co-researcher and enabling both client and researcher to see each other as fellow human beings.
- The PCE therapy researcher creatively and flexibly adapts research methods to the research topic and questions at hand.

These precepts inevitably lead PCE researchers to qualitative methods, especially empirical phenomenology (the Duquesne approach; see, for example, Wertz, 1983) and grounded theory analysis (Strauss & Corbin, 1998), along with variants such as heuristic research (Moustakas, 1990), consensual qualitative research (Hill, Thompson, & Williams, 1997) and autoethnography/participatory inquiry (Etherington, 2004; Heron, 1996). These qualitative methods, although they differ in important ways, share many common interests with each other and with PCE therapy; these include the central place accorded empathy, attention to issues of meaning, suspension of the natural attitude of having to arbitrate the nature of reality, and valuing empowerment as a goal and process in research (Mearns & McLeod, 1984). Methods such as these can be used to study just about any human experience, from being criminally victimized (Wertz, 1983) to loneliness (Moustakas, 1990). (See Box 31.2 for a list of common qualitative research strategies.)

Box 31.2

What do qualitative psychotherapy researchers do?

The different forms of qualitative research can sound mysterious and confusing; however, they typically involve a series of common concrete steps. Elliott and Timulak (2005) provide a list of common practices used by qualitative researchers:

- Negotiating with the informant-client in a transparent, collaborative manner over the nature of the participation.

- Carrying out the interview in a careful, intentional manner, helping the informant to stay focused and clarifying their meanings as they attempt to put them into words.
- Transcribing the recording of the interview at the appropriate level of detail and accuracy.
- Preparing the data record by breaking it into meaning units and dropping irrelevant material.
- Constructing categories or themes to describe each meaning unit.
- Putting meaning units into existing categories, where these apply.
- Clustering or connecting categories or themes with one another in order to develop a model or story of the phenomenon.

Promising possibilities for PCE therapy research

Given the considerations reviewed so far in this chapter, I think that there are many questions open for PCE therapy research, and these will be covered in turn below.

How effective are PCE therapies with specific client populations?

Both traditional group designs and RCTs continue to be very much needed, both for commonly studied populations such as individuals with depression and especially for less-studied populations such as those with health problems (for example, coping with cancer) and psychosis. It would also be a very good idea for researchers in our tradition to study anxiety problems, instead of leaving this topic entirely to CBT approaches.

How effective are PCE therapies with particular clients?

An alternative to positivist therapy research of the sort just described is the systematic case study design, in which a single client's treatment is studied carefully and in detail in order to draw inferences about (1) whether the client changed substantially, (2) whether therapy contributed substantially to those changes, and (3) how the changes came about (Elliott et al., 2009). Elliott and Zucconi (2006) describe a research protocol suitable for this sort of research, including a combination of qualitative and quantitative data collection formats.

What are the effects of the facilitative conditions on the outcome of PCE therapies?

In a recent meta-analysis of process-outcome research on therapist empathy (Elliott, Bohart, Watson, & Greenberg, 2011), we found only eight studies of PCE therapies in which this relationship had been studied. In fact, Rogers' key theoretical claim has

only rarely been applied to the therapy he founded. This sort of research question is highly appropriate for naturalistic samples of PCE therapy, in which empathy is measured by client, therapist and/or observers during therapy and used to predict client of pre-to-post change. (See Elliott et al., 2011, for more suggestions for research on therapist empathy.)

What are the immediate in-session effects of therapist facilitative responses on the depth of client processing?

The relationship between specific therapist facilitative responses (for example, empathic reflections) and productive client responses within PCE therapy sessions has been studied extensively by Sachse (see Sachse & Elliott, 2002, for a summary). However, most of Sachse's somewhat controversial findings, which suggest a high degree of therapist influence on client process, have not yet been replicated by others, making this a prime topic for further PCE therapy research.

What do clients experience as most helpful in PCE therapy?

If the preceding research topics seem too positivistic, a purely phenomenological strategy can be used, in which clients are asked to describe in their own words what they found most helpful, either in particular sessions, using the Helpful Aspects of Therapy Form (Llewelyn, 1988), or overall looking back over their therapy, using the Change Interview (Elliott, Slatick, & Urman, 2001). These accounts can then be analyzed using grounded theory analysis or a similar qualitative method (for more information, see, for example, Elliott & Timulak, 2005).

What are the characteristics of transformative moments in therapy?

The idea that there are special moments of insight, awareness, relief or other forms of personal healing in therapy is a key theme in the PCE therapy literature, dating back to Rogers' writings on the therapy process (see, for example, Rogers, 1961). Using the Helpful Aspects of Therapy Form or the more intensive Brief Structured Recall method (Elliott & Shapiro, 1988), PCE therapy researchers can identify important moments from clients' perspectives and then investigate them further in order to unpack the process of change, including the momentary qualities of the client's experience and the accompanying discourse.

What do PCE therapists know about how to help facilitate different kinds of productive client work in therapy?

Experienced, skilled PCE therapists have large amounts of implicit knowledge about therapeutic processes, that is, what to do when. Using tape-assisted recall methods (Elliott, 1986) and task analysis (Greenberg, 2007), the wisdom of experienced PCE

therapists can be tapped into by researchers. How do skilled PCE counsellors help their clients get what they want to get out of sessions? What markers do these counsellors look out for in sessions, and what do they do in response to these markers?

What are the effects and change processes in PCE therapy/counselling training?

Finally, we do not understand much about the outcomes of training courses in PCE therapy or counselling. In the future, such courses are likely to be called upon to demonstrate their effectiveness, in terms of personal and professional functioning and ultimately quality of process and outcome with clients. We also do not understand the change processes in our training courses, or which training practices are effective or ineffective. (See Elliott & Zucconi, 2006, for some suggestions on this, and see also Box 31.3.)

Other research questions and investigative strategies are possible, for example participatory research (Whyte, 1991) and narrative research (McLeod, 2001).

Box 31.3

How to get involved in practice-based research

Elliott and Zucconi (2006) have offered a set of practical suggestions for PCE therapists to get involved in research:

- Contribute to dialogues on how to measure the effects of PCE therapy and training.
- Join online and face-to-face discussions or PCE research groups and networks and help to assemble research protocols and sets of measures.
- Begin using simple research tools with their own clients and in their own training setting, including, for example, brief quantitative measures of client problem distress and therapeutic alliance, along with systematic collection of background information about client and therapist.
- Help with translations of research instruments, or develop research protocols for specific client population (for example, people living with schizophrenia).
- Contribute to psychometric research to improve existing instruments.
- Take part in formal or informal collaborations with other training centers in order to generate shared datasets.

Conclusion

Clearly, many possibilities exist for person-centred therapists to reclaim their scientific heritage, building on recent developments and continually emerging new

resources for practical, humanizing research that is completely consistent with the core values and practices of PCE therapies. Not only is research a political necessity, it is also one of the purest expressions of the actualizing tendency.

Points for reflection

- Are researcher allegiance effects inevitable in comparative outcome studies? How might they be reduced?
- What might truly person-centred outcome research look like?
- What are the underlying philosophical assumptions of RCTs?
- What are you personally curious to learn about PCE psychotherapy?
- What research methods would you be willing to implement in your practice with clients?

Key readings

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A timely review of research evidence on PCE therapies and person-centred approaches to research.

- Elliott, R., & Farber, B. (2010). Carl Rogers: Idealistic pragmatist and psychotherapy research pioneer. In L. G. Castonguay, J. C. Muran, L. Angus, J. A. Hayes, N. Ladany, & T. Anderson (Eds.), *Bringing psychotherapy research to life: Understanding change through the work of leading clinical researchers* (pp. 17–27). Washington, DC: American Psychological Association.

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- Elliott, R., & Zucconi, A. (2006). Doing research on the effectiveness of psychotherapy and psychotherapy training: A person-centered/experiential perspective. *Person-Centered and Experiential Psychotherapies*, 5, 82–100.

Presents a rationale and framework for practice-based research on psychotherapy and counselling.

- McLeod, J. (2003). *Doing counselling research* (2nd ed.). London: Sage.

A clearly written introduction that covers the main varieties of counselling/psychotherapy research.

■ Sanders, P., & Wilkins, P. (2010). *First steps in practitioner research: A guide to understanding and doing research for helping practitioners*. Ross-on-Wye: PCCS Books.

A detailed but straightforward overview of qualitative and quantitative research methods for practitioners and students.

■ http://experiential-researchers.org

The Network for Research on Experiential Psychotherapies, a website maintained by the Focusing Institute. Information on research instruments, protocols and promising leads for research.

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32
Person-centred approaches as cultural leadership

MAUREEN O'HARA

This chapter discusses:

- Rogers' efforts in the larger social sphere putting basic person-centred principles to work in the larger world
- The untapped potential of person-centred work as a practical basis for social transformation
- The view that the principles of the person-centred approach elaborated by Rogers and his colleagues over 60 years of practice are *evolutionary* – they enable the expansion of human capacity to deal with the challenges we now face
- The view that the principles of the person-centred approach are emancipatory in providing non-violent contexts in which conditions that stifle human growth can be identified and transcended
- Rogers' personal journey as a thinker and as a reflexive practitioner over his lifelong commitment to social transformation
- That the social transformation initiatives of Rogers and person-centred approach practitioners suggest possible areas where the principles of the person-centred approach can make a humanizing difference in a threatened world

Rogers as prophet

Most psychologists today think of Rogers in terms of his influence on the practice of psychotherapy and counselling. In a survey to identify major influences on American practitioners, Rogers was ranked highest (Cook, Biyanova, & Coyne, 2009). And

little wonder. As the chapters in this book collectively attest, Rogers' impact on the field of psychotherapy and counselling has been and continues to be profound. But his interest in therapy always took place against a deeper and ultimately more ambitious mission, that of social reformer and cultural leader. Rogers' aim was to transform the world. Cultural leaders emerge at times of social turmoil, and their genius is to makes sense of and articulate the collective aspirations for a better future, to sense the emergent tide of history and to offer vision and practice to shift the culture in the direction of the desired change (Brueggemann, 2001; Omer, 2005). Although sometimes coy about admitting it, Rogers was such a leader.

The chapters in this volume have emphasized that at the core of Rogers' person-centred approach is the observation that within every organism, including human beings, is an 'underlying flow of movement towards constructive fulfilment of its inherent possibilities' (Rogers, 1978, p. 7). This flow – which he identified as an actualizing tendency – can be blocked and distorted by adverse circumstances. But if certain psychological conditions are present – namely engagement, genuineness, acceptance and empathic understanding – human beings move towards wholeness as individuals and cooperative coexistence as groups and societies. This simple affirmation of a creative force in the universe animates Rogers' work at every level, from individual counselling to groups and to hopes for the evolution of consciousness, and, as I will describe, has become part of the core orienting commitment of a new generation of social activists.

Over this 60-year period from 1922 to 1987, Rogers' concerns for human welfare on the societal and cultural levels never faltered. He wrote on internationalism, foster care, social work legislation, parent–child–community problems, post-war concerns of soldiers, wartime issues of families, social tensions, racism, the professional relationship, communication in the workplace, the control of human behaviour, human nature, education, addiction, the politics of education, teacher training, encounter, marriage, 'persons of tomorrow', the good life, self-directed institutional change, the relationship between Eastern and Western values, widespread loneliness, the large group process as pedagogy for social change, positive ageing, nuclear war, peace activism, evil, white privilege, Soviet professionals and conflict in Central America (Rogers & Russell, 2002).

After he moved to California in 1963, Rogers' interest turned almost exclusively towards putting person-centred principles to work in larger sociopolitical contexts. So, while person-centred theory and practice was being further developed as a method of psychotherapy around the world, others, including Rogers, were exploring the implications of the same principles in groups, organizations and societies to meet the rising social challenges of the times, and at the same time to create the conditions for a possible next step in the evolution in consciousness.

A world in transition

In his last years, Rogers actively explored the contours of a new worldview or paradigm adequate to life in the twenty-first century. He understood just how radical the

cultural transformation underway really is. He writes, 'There are many new developments today that alter our whole conception of the potentialities of the individual; that change our perceptions of 'reality'; that change our ways of being and behaving; that alter our belief systems' (Rogers, 1980, p. 343).

Rogers came to believe that the world was heading for a troubled and turbulent period – a new Dark Age – but one that contained the seeds of social transformation. In the anxiety, pain and hope expressed by people from sunny California, to racially divided South Africa, to Brazil in the process of emerging from dictatorship, to Japan making the huge post-war transition to a more open democracy, and to the Soviet Union, where ethnic fault lines were only held in place by brutal oppression, he sensed that the diverse people he encountered in person-centred gatherings were like miners' canaries, signalling an early response to both the looming threats and the seemingly boundless opportunities of the times.

The most pressing threat in the 1970s, of course, was the threat of nuclear war – Rogers talked of 'nuclear planetary suicide' (Rogers & Ryback, 1984) – but environmental degradation, population growth, racial and ethnic oppression, an energy crisis and a seemingly endless war in South East Asia were already on the minds of people across the world. The book *Limits to Growth*, published by the influential Club of Rome in 1972, had shocked the world with its description of the interpenetrated intractable problems as a 'global problematique' and predicted catastrophic environmental collapse if we did not change course (Meadows, Meadows, Randers, & Behrens, 1972). Social movements emerged focusing on individual human rights, equality of races and genders, empowerment of ethnic communities, and indigenous peoples; the beginnings of environmental awareness and new forms of spirituality; more transparent and open governance; an emphasis on better communications at all levels; and the astounding advances in science and technology.

In person-centred groups convened across the world at that time, listening deeply to the anxieties and aspirations expressed by participants it was possible to sense that radical changes were afoot that were unravelling the fabric of twentieth-century life. As early as the 1960s and 70s, Rogers and his co-workers recognized that civilization was in the midst of a change of eras in which many foundational assumptions that had provided a sense of cultural coherence and social and psychological stability were unravelling.

Since then, the pace of change has only accelerated, the threats and opportunities have intensified, and the world has become a hyperconnected, complex, fast-changing, bewildering place. The resulting incoherence poses threats to social order and human survival, but at the same time it is opening up possibilities for creativity and expansion of consciousness. The future will be determined in large measure by the decisions human beings make collectively and the level of consciousness of the individuals in those collectives.

The person-centred approach as political theory

By his own admission, Rogers was slow to recognize that the person-centred approach has political as well as psychological implications, but by the mid-1970s he was becoming aware that many saw person-centred approach as an overtly political stance (Rogers, 1978). At a multicultural workshop in El Escorial, Spain, attended by people from 26 nations, Rogers was challenged by participants from then Communist Eastern Europe and Soviet Union to explain his politics as they explored whether person-centred groups were a form of American cultural imperialism. In response, he articulated the political philosophy implied by the principles of person-centred approach (Rogers, 1982; Box 32.1). Rogers did not say that this was or should be the political ideology of everyone whose practice is client or person-centred. But these were the values that animated him and his efforts to move the world.

Box 32.1

Rogers' political position

> Politics involves the question of where power is located, who makes the choices and decisions, who carries out or enforces those decisions, and who has the knowledge or data regarding the consequences of those decisions. It involves the strategies involved in the taking of power, the distribution of power, the holding of power, and the sharing or relinquishing of power. (Rogers, 1982, p. 8) (provided by Gay Barfield)

In Rogers' view, the elements of person-centred approach praxis that contribute to this power-sharing process include individual empowerment, careful deliberative and participatory decision-making, awareness of and responsibility for the effects of actions on others and the downstream consequences of actions, individual alignment with the group's emergent consensus through choice, self-discipline and self-control, and openness to feedback, change and redirection, flexibility and reflection. His political values were grounded in the psychological conditions of mutual respect, a capacity for empathy across differences, egalitarian engagement and collaborative decision-making.

The person-centred approach as a praxis for social transformation: peace work

Perhaps as a consequence of having seen the disastrous effects of two world wars before he was 40, Rogers worked unceasingly in the quest for peace – locally among groups in conflict, and globally with heads of state in attempts to resolve international strife. At the height of sectarian violence in Northern Ireland, Rogers and Pat

Rice, a colleague from the Center for Studies of the Person, facilitated encounters between Catholics and Protestants in an attempt to ease antagonisms and seek reconciliation. One encounter took place immediately following bomb blasts that had killed dozens including schoolchildren and is captured in the film *The Steel Shutter*, which has lost none of its power to move audiences with its hopeful example of social healing (McGaw, 1973). In partnership with South African psychologist Len Holdstock and others, Rogers and a team of colleagues led encounters between blacks and whites in segregated South Africa. He facilitated encounters among diverse ethnic groups in Pre-Perestroika Soviet Union, and with Norman Chambers and Bob Lee he facilitated heated meetings between American blacks, whites and Chicanos in racially divided cities in the USA.

In 1984, Rogers and co-director Gay Barfield (then Swenson) created the Carl Rogers Institute for Peace at the Center for Studies of the Person, in La Jolla, California (Swenson, 1987). In 1985, the Institute convened its first international peace workshop, The Central America Challenge, in Rust, Austria, with high-level US and international diplomats and lay leaders from 17 countries in attendance. A second follow-up workshop was held in Costa Rica, with the support of the University for Peace of the United Nations, and of Presidents Óscar Arias of Nicaragua and Rodrigo Carazo of Costa Rica, and other US and international diplomats who chose to gather shortly after Rogers' death with the goal of continuing to apply person-centred principles in their search for peace in the region. Rogers' work towards peace was recognized in 1987 with a nomination for the Nobel Peace Prize. His family received news of the nomination the day after he died.

Peace initiatives grounded tacitly and explicitly in person-centred principles are ongoing around the world. Here are a few of many examples.

The Common Bond Institute in the USA, whose director Steve Olweean explicitly acknowledges person-centred principles as the core of its approach, has convened encounters between antagonists for over 20 years. In partnership with the Harmony Institute of St Petersburg, Russia, Common Bond organizes the annual International Conference on Conflict Resolution in St Petersburg , and Engaging the Other conferences in the USA that bring together peace activists from all over the world to share practices and inspire further action. They offer training to peace groups in the Middle East and ethnically divided cities in the West. Common Bond's approach focuses on deep listening, engagement, empathy and transparency, and is grounded in the same faith in an emergent force in the universe that can be trusted to move people towards mutual respect. Common Bond is included in three-volume book, *The New Humanitarians*, as an example of visionary work in areas of violent conflict (Stout, 2009). In 2011, an encounter and training programme for facilitators from all the stakeholder groups was held for the first time in Jordan, focusing on healing and reconciliation between Israelis and Palestinians seeking a person-to-person way forward.

Colin Lago and his colleagues offer person-centred approach-informed training workshops in diversity and multicultural practices around power and oppression (see Chapter 29).

Natalie Rogers and other person-centred expressive arts practitioners have for many years offered international workshops and training as a means of finding inner and outer peace (see Chapter 16).

At the Joan B. Kroc Institute for Peace and Justice at the University of San Diego, a former colleague of Rogers, Dr Dee Aker, is the Deputy Director. Her work involves peace and reconciliation work in developing nations, supporting women' s efforts at peaceful negotiation, and training young people in diplomatic approaches to problem-solving, as well as developing an international women's court of justice at the Hague (see www.sandiego.edu/peacestudies/ipj/about/bio.php?id=422).

Emancipatory learning

Brazilian psychologist Bruno Fróis dos Reis spent a year at Center for Studies of the Person in La Jolla in 1974. During the years of dictatorship in Brazil, he had seen friends exiled, tortured and 'disappeared' for speaking out against oppression. He saw encounter groups, with their 'here-and-now,' individual and interpersonal focus, as a possible 'Trojan Horse' bringing emancipatory practices of personal empowerment and authentic communication to a traumatized society under the noses of a still vehemently anti-Marxist establishment. Descriptions from group encounters in Brazil suggest that he was right (Bowen, Miller, Rogers, & Wood, 1979). Three decades later, person-centred work in Brazil remains strong. Some of today's leadership of the person-centred movement in Brazil were participants in those first encounters. They and generations of their students continue to organize person-centred encounters across Latin America in which the processes of personal and political freedom are experienced by 'living' them.

In the USA, leaders of the person-centred approach continue to address issues of community process, power and emancipation. In June 2011, Peggy Natiello, Carol Wolter-Gustafson and Colin Lago convened a community encounter aimed at exploring the person-centred praxis for acting globally. Encounter groups focused on emancipatory learning are ongoing in Japan, Austria, France, the UK, Brazil, Italy and Australia.

Critical issues in power dynamics

A cautionary note is needed here. A clear understanding of Rogers' core political and ethical stance is nowhere more critical than in large group person-centred approach events. Rogers' close colleague John K. Wood describes some of the potentially coercive effects of large group dynamics when core ethical provisions of person-centred approach such as trust in the self-organizing emergent actualizing principle are replaced by instrumentalist aims, however worthy.

After more than 50 large group encounters in several countries, O'Hara and Wood argued that whether a large group encounter is a safe site for emancipatory learning by individuals and by collectives, or is potentially destructive or even cult-

inducing, requires faithful adherence in practice to core political commitments (O'Hara, 1989; Wood, 2008). Large group events that are directed by a charismatic leader, where the process is designed to ends that are specified by the leaders, where participant interactions are structured to induce compliance, even if unintended, or prevent conflict or the emergence of deviant opinions, and where trance-inducing rituals are introduced without explanation, permission or debriefing, may produce certain kinds of positive personal awakenings and cognitive reorganization, but may be far from emancipatory. Instead, they cultivate a kind of encounter group 'true believer' orthodoxy. For a sobering discussion of the manipulative extremes of large group events, read Philip Cushman's *The Politics of Transformation* (Cushman, 1993).

The person-centred approach in organizations

In the first major expression of his ideas, Rogers (1942) proposed applications of client-centred counselling approaches in the workplace. His concerns were about group tensions, individual dissatisfaction and their effects on the wellbeing of those in the workplace (Rogers, 1947). At a time when advice-giving, directive, hierarchical, command and control management, and manipulation by behavioural engineers were the order of the day, Rogers' discoveries offered a new ethics for human relationships at work (Farson, 1975).

These humanistic ideas were eagerly embraced by a post-war generation seeking to participate in empowered ways in all aspects of life. When the *Harvard Business Review* selected its top 15 most influential business articles in 1998, they included a 1952 article by Rogers (co-authored with Fritz Roethlisberger, one of the authors of the famous Hawthorne studies). In introducing the article, Gabarro reflects that, 40 years later, these straightforward but hard to practise relational rules had contributed to a sea-change in workplace culture (Rogers & Roethlisberger, 1952, 1991) that led to the worker empowerment movement, the development of more participatory management approaches and increasing emphasis on the 'soft skills' (of effective human relationships) in the board room, in management, on the shop floor, in sales and in customer service.

As a tacit dimension of practice, person-centred principles have been incorporated by generations of organizational theorists and practitioners. Many of the classic works on process consulting, organizational behaviour, teamwork and leadership take the core person-centred relational conditions of empathy, congruence, acceptance and faith in the process, as givens (Bennis, 1989; Covey, 1989; Farson, 1996; Goleman, 1998; Isaacs, 1999; Schein, 1998; Senge, 1990), although only Bennis and Farson fully acknowledge their debt to Rogers.

Today's workplaces make intense psychological demands on employees, especially leaders. There is a growing recognition of the need to expand consciousness and cultivate higher order twenty-first-century capacities. Providing support services to their best people to help them cope with the complexity of conditions in the emerging global society and develop higher levels of personal effectiveness becomes

essential. Person-centred leadership development includes (but is not limited to) a focus on development of the necessary higher order psychological capacities to succeed in leadership roles in today's uncertain times (Bennis, 1989).

Recently, there has been renewed interest in the management challenges of networked and non-hierarchical organizational that stresses the importance of informal governance processes over governance structures (Fairtlough, 2005). Fairtlough suggests that key to effectiveness in these new organizational forms are 'interpersonal process skills, the special skills for empathic dialogue, teamwork and mutual respect' (p. 63). A focus group study of young social entrepreneurs in San Francisco in 2011 emphasized the need for more focus in management schools on the self-care and interpersonal skills needed to thrive in the fast-paced multi-tasking networked world in which they find themselves (O'Hara, 2011). These needs are reflected in the meteoric rise of personal and professional coaching.

Healthcare's next wave

As the cost of providing healthcare escalates exponentially, communities are straining to find alternative ways to address population health needs. One such project is Kitbag, developed by Dr Margaret Hanna, Deputy Director of Public Health for Fife in Scotland. This is a set of self-care 'resources in a bag' designed with person-centred principles at its core and expressed in every element (www.internationalfuturesforum.com/iff_kitbag.php). It contains 'presence' cards with prompts about breathing and awareness in the here-and-now; 'transform' cards with prompts about hope, change and action; scented massage oil for self-soothing; space for photos and precious objects; and egg-timers to count off intervals for silence or for speaking and listening. Kitbag is not a 'how to' – people use it in whatever way suits them.

Although the elements are explained, Kitbag offers no direction other than to suggest that people work with it for about 30 minutes every few days and get into a routine of paying attention to themselves, their concerns and their potentials. So far, with the help from grants from funding agencies, Kitbag has been provided to carers, abused women in a safe house, first responders, women in prison and NHS nurses, with a special version developed for children. A group of disabled individuals are producing it, and new groups are signing on to use the Kitbag. The latest users are wounded military veterans who reported, after they piloted it, that they liked the fact no one told them how to use it, no one diagnosed them and no one measured their 'progress'. They did ask for one design modification after the pilot. In place of cards with prompts about hope in their version, they wanted pictures of the Scottish countryside and lines from the war poets from the First and Second World Wars. As the project is an emergent co-creation, these changes were welcome and incorporated.

The Fifth Wave is a project of the Glasgow Center for Population Heath and International Futures Forum, whose aim is to transform thinking about healing and health in Scotland. Fifth Wave's focus is on persons not patients, on wellness not sickness, on emergence not objectification.

Studies suggest that a large amount of the ill-health in older people occurs because they are lonely (Leicester, 2011). The Fife SHINE project launched in Scotland in the summer of 2011 links people in the community who enjoy caring for others with folks who need care (www.internationalfuturesforum.com/projects.php?pid=45). The carers – mostly people who are older themselves – are reimbursed for their expenses such as petrol but are not on a salary. The aim here is to demonstrate that a community wellness approach to care for older people can reduce costs and improve service. Most important is the nurturance of both community and relationships. What differentiates this project from a more common 'volunteer' process is that the currency here is friendship and presence – given, received and given back.

Basic to these projects is the belief in a force in the universe that moves us in the direction of wholeness and transcendence, that patients heal themselves in partnership with people who care about them, empathize with them and respect their inborn capacity to grow and transcend (Lyon & Hannah, 2003).

Mental health capacity building in Afghanistan

Since 2010, the University of Strathclyde (Glasgow, UK), the University of Herat (Afghanistan) and the non-governmental organization PeaceWaves International Network (Genoa, Italy) have been collaborating in two projects funded by the British Council. One of these is under the scheme called the INSPIRE International Strategic Partnership, which began in January 2011. The project is to conduct two training courses for Afghan practitioners in person-centred/experiential counselling skills over 3 years. The course is experientially co-constructed between tutors and participants on a daily basis, in respect of the local cultural and traditional values. In a society wracked by generations of war and trauma where mental health needs are massive and services scarce, building local capacity is urgent. The aim is to train trainers who can apply and replicate the programme autonomously at the University of Herat and other several Afghan organizations (L. Berdondini & S. Grieve, personal communication, 23rd August, 2011).

Building sustainable communities

Community initiatives to address the multiple challenges humanity now faces are a growing force worldwide. In *Blessed Unrest*, cataloguing what he calls the 'largest movement in history,' Paul Hawken reports that the WiserEarth database (www.wiserearth.org) now lists over a million different non-profit and social entrepreneurial groups worldwide that are working to bring about positive change (Hawken, 2007). Of these, 32,000 focus on community issues. A glance at the descriptors used by these groups to identify their values and focus reveals an astonishing alignment with person-centred approach praxis. Participation, personal and community empowerment, authentic communication, dialogue, mutual respect, collective deliberation, talking across differences, active listening, empathy, egalitarian govern-

ance, transformative conversation, collective intelligence, respectful relationships and non-violent communication are a sample of the 'keywords' that show up frequently. It is unlikely that the current participants of many of these groups have had direct contact with Rogers or the person-centred approach, but the almost universal commitment to these same principles suggests that the ideas have now gone viral and become an uncontested open-source resource for community development and social change.

Conclusion: emerging challenges

In the early years of the twenty-first century, the entire world is well into a state of unprecedented challenges and uncertainty that many argue are of sufficient magnitude for the survival of planetary life support systems to be in jeopardy. While most official thinking about the future focuses on technology, energy resources, economics and disease, in the coming decades psychological capacity may have a more decisive role to play in how humans fare (O'Hara, 2010).

In the developed world, people schooled in the basic assumptions of the modern era face what have been described as the conditions of 'liquid modernity', in which the anchors of identity, morality and epistemology, and the social contract between the government and the governed, are in motion (Bauman, 2007; Leicester & O'Hara, 2009; O'Hara, 2010). The sense of psychological coherence and shared meaning that allows societies to cooperate to cope with their challenges can no longer be taken for granted as the ideal of 'progress' that once animated both the physical and social sciences is seen through more sceptical twenty-first-century lenses.

At the same time, in the developing world, where traditional patterns of life have remained deeply coherent and unchanged for centuries, people must now contend with the radically destabilizing influence of an unbidden influx of Western people and ideas. How should a tribal Bedouin woman understand the values of an industrialized Israeli or a British oil company executive? And yet if she is to participate as a sovereign person in the decisions that will affect her and her children, she must. How will white Christian activists cooperate with urban multiethnic minorities in the USA to tackle unmet mental health needs and rampant drug addiction in declining economic circumstances? And what new ideas will emerge for and from the ageing populations that will maintain the sense of dignity, empowerment and community they have gained over the last half-century? These challenges are not simple problems that can be solved at the level of consciousness at which they were created. They demand a transformative response. They require that human beings grow, become more fully human and achieve a higher level of consciousness so as to act with more wisdom.

This is a time for a new generation of transformative cultural leadership. The threats and opportunities of today are similar to but more pressing than those that drew Rogers and his colleagues 50 years ago. There is an urgent need for people to develop a greater capacity to make conscious choices based in empathy and cooperation, to work to enhance human sovereignty and dignity, to establish mutually empowering relationships, and to make wise and ethical choices and policies.

It is often at points of confusion, cognitive dissonance and anxiety that new advances in consciousness – breakthroughs – occur. In a book that had a huge impact on Rogers, social historian L. S. Stavrianos (1976) proposed that, when empires come to an end, the collapse is never total. There is always old wisdom to be drawn upon, to patch together with new ideas and new tools invented in the face of new challenges. Humankind has so far answered previous threats to its survival by grit, invention and creativity. When people can contain their anxiety long enough to tolerate and actually indwell in dissolution of past certainties, and can be supported by members of their communities to live at the emerging edge of their being, as they sometimes are in person-centred communities and groups, they can find the edge of innovation and insight with which to address the challenges they face. And when they do, consciousness expands and perhaps even evolves.

If a new generation of practitioners wishes to take up the social transformation project at the heart of person-centred approaches, they will find much to work with. They will not find a map on which a clear direction is laid out, or a 'how to' manual that can be applied to specific ends. Instead, they will find a compass that they can use to orient themselves to the self-organizing capacities inherent in all human systems. If they align their own creative imagination, the simple yet demanding relational skills based in the basic person-centred approach core conditions, and a sense of what needs to done, the person-centred approach as a praxis has untapped potential as an approach to social transformation in the liquid modern world.

Points for reflection

- How and why has person-centred thinking come to focus so much on individual counselling and psychotherapy?
- What social issue lends itself to a person-centred approach to transformation?
- What community do you see in which mutually empowering relationships are needed and could be nurtured?
- What human capacities are likely to be needed to if humankind is going to be able to tolerate the dissolution of past certainties?

Key readings

- O'Hara, M., & Leicester, G. (2012). *Dancing at the edge: Competence, culture and organization for the 21st century*. Axminster, Devon: Triarchy Press.
- Stout, C. E. (2009). *The new humanitarians: Inspiration, innovations and blueprints for visionaries*. Westport, CT: Praeger.

A wide review of projects with a person-centred heart, written by a psychologist.

■ Hawken, P. (2007). *Blessed unrest: How the largest movement in history is restoring grace, justice, and beauty to the world*. New York: Penguin.

An even wider range of projects large and small that show how to put the values of person-centred approach into the world.

The following websites are a good gateway for those interested in going further:

■ International Futures Forum: www.internationalfuturesforum.com

■ Afternow, directed by Dr Phil Hanlon at the University of Glasgow – projects, ideas and methods for putting a person-centred view at the centre of social policy: www.afternow.co.uk

■ Global Initiatives, directed by Chris Stout: http://centerforglobalinitiatives.org

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33 Resources

ROELF J. TAKENS

This chapter can be dipped into and used as a source of information and does not need to be read sequentially from beginning to end. Website addresses are given in the final part of this chapter.

National organizations

Around 200 national organizations and training centres around the world are dedicated to researching and applying the principles developed by Rogers and the person-centred approach (Kirschenbaum & Jourdan, 2005). Examples of some of the key national organizations listed by these authors are presented in Table 33.1. Membership numbers of these organizations vary considerably, from a handful of persons when *training institutes* are at stake (for example, the PCA Institut Praha in Prague, and the PCAI-F in France) to a few thousand when it concerns *national associations* directed at *professional interests*, such as the GwG in Germany (which has more than 4,000 members), the BAPCA in Britain (over 1,000 members) and the VCgP in the Netherlands (about 600 members). Noticeably, in the USA, the ADPCA counts only a few hundred members, pointing to a diminishing interest in the person-centred approach in that country over the past decades.

International cooperation

International cooperation between professionals and researchers is more common nowadays than ever before. However, in humanistic and person-centred circles, networking is not as intense as it seems to be in other orientations. This may be because of the emphasis on personal freedom and the autonomy of the individual. It is known that Rogers himself hated bureaucracy and institutionalization. For instance, he showed great reluctance when he was asked to endow his name to associations such as the Vereniging voor Rogeriaanse Therapie in the Netherlands

(founded in 1962). He was worried that it would foster a personality cult and lead to rigidity with respect to further developments of the approach. Rogers' death in 1987 freed up a great deal of energy and initiative by person-centred theorists, researchers and practitioners around the world, making the person-centred approach more of a broad-based, international movement than it ever was during Rogers's lifetime (Kirschenbaum & Jourdan, 2005).

Table 33.1 Examples of person-centred organizations around the world

Country	Organization
Argentina	A.E.D.E.C.e.P. –Asociación para el estudio y desarrollo del Enfoque Centrado en la Persona
Austria	PCA – Person-Centered Association in Austria
Belgium	A.F.P.C. – Association Francophone de Psychothérapie Centrée-sur-la-Personne et Expérientielle
	VVCgP – Vlaamse Vereniging voor cliëntgerichte psychotherapie (Flemish-speaking society)
Brazil	C.E.P./RS – Centro de Estudos da Pessoa
Canada	CRAM – Centre de Relation d'Aide de Montréal
Czech Republic	PCA Institut Praha
France	PCAI-F – Person-Centered Approach Institute
Germany	GwG – Gesellschaft für wissenschaftliche Gesprächspsychopherapie
Greece	PCA – Hellenic Association of Person-Centered Approach
Hungary	HAPCCPM – Hungarian Association for Person-Centered Psychotherapy and Mental Health
Italy	IACP – Istituto dell'Approccio Centrato sulla Persona
The Netherlands	VCgP – Vereniging voor Cliëntgerichte Psychotherapie
Portugal	APPCPC – Associação Portuguesa de Psicoterapia Centrada na Pessoa e de Counselling
Scotland	PCT – Person Centred Therapy
South Africa	APCASA – Association for the Person-Centered Approach South Africa
Switzerland	SGGT-SPCP – Swiss Association for Person-centered Psychotherapy and Counseling
United Kingdom	BAPCA – British Association for the Person-Centred Approach
United States	ADPCA – Association for the Development of the Person-Centered Approach

Note: Reproduced from Kirschenbaum and Jourdan (2005).

Networks

The most important international networks in the field of the person-centred approach are:

- the *World Association for Person-Centred and Experiential Psychotherapy and Counseling* (WAPCEPC);

- the *Network of the European Associations for Person-Centred and Experiential Psychotherapy and Counselling* (PCE Europe, formerly NEAPCEPC);
- the *Association for the Development of the Person-Centered Approach* (ADPCA).

In the USA, the *Center for Studies of the Person* (CSP), co-founded by Rogers in 1968, is still functioning, gathering people from all over the world. However, the organization no longer holds the leading position that it had in the days of Rogers.

WAPCEPC

The World Association for Person-Centered and Experiential Psychotherapy and Counseling was founded in 1997 during the Fourth International Conference on Client-Centered and Experiential Psychotherapy in Lisbon, Portugal. The statutes were confirmed during the next international conference in Chicago in 2000. Since that time, WAPCEPC has come to be seen as the most important umbrella organization, connecting person-centred therapists and counsellors worldwide. According to its statutes, the aim of the WAPCEPC is to provide a global forum for those professionals in science and practice who:

- have a commitment to the primary importance of the relationship between client and therapist in psychotherapy and counselling;
- hold as central to the therapeutic endeavour the client's actualizing process and phenomenological world;
- embody in their work those conditions and attitudes conducive to the therapeutic movement first postulated by Carl Rogers;
- have a commitment to an understanding of both clients and therapists as persons, who are at the same time individuals and in relationship with others and their diverse environments and culture;
- have an openness to the development and elaboration of person-centred and experiential theory in light of current and future practice and research.

This forum function is realized in different ways:

- by publishing a journal (*Person-Centered and Experiential Psychotherapies*);
- by (co-)organizing international conferences (the first to be organized under the auspices of the WAPCPEC being the Sixth International Conference on Client-Centered and Experiential Psychotherapy and Counseling at Egmond aan Zee, the Netherlands, in 2003);
- by supporting people in their joint efforts to conduct research in the field of person-centred/experiential psychotherapy (for example, the Network for Research on Experiential Psychotherapies).

Members of WAPCPEC can be persons as well as organizations, such as institutes and associations. In 2011, the association consisted of 300 individual members and 31 institutional members.

PCE Europe

The history of the Network of the European Associations for Person-Centred and Experiential Counseling and Psychotherapy (PCE Europe, formerly NEAPCEPC) goes further back than that of the WAPCPEC, to the year 1989. Then, representatives of national associations from a range of European countries met in Salzburg to talk about political issues and developments regarding their profession, the position of the person-centred approaches in their countries in particular. This round-table discussion was a continuance of the yearly meetings of the boards of the German-speaking countries (Austria, Germany and Switzerland). The locations of subsequent gatherings can be seen in Table 33.2.

Table 33.2 Location of European network gatherings

1990	Bonn	2002	Vienna
1991	Zürich	2003	Egmond aan Zee
1992	Vienna	2004	Dijon
1993	Amsterdam	2005	Lisbon
1994	Gmunden	2006	Potsdam
1995	Aachen	2007	Cirencester
1996	Zürich	2008	Norwich
1997	Kasterlee	2009	Szeged
1998	Luxemburg	2010	Rome
1999	Athens	2011	Bordeaux
2000	Budapest	2012	Antwerp
2001	Brussels		

In 1998, the NEAPCEPC network was officially founded. Its general purpose was to support client-centred/person-centred organizations throughout Europe and to ensure the presence of the approach on the European level. It adheres to the same principles as does WAPCEPC (see above). It also has liaisons with the European Association for Psychotherapy (EAP) and the European Association for Counselling (EAC).

According to its website (www.europsyche.org), the EAP represents 128 organizations (including 24 national umbrella associations and 17 European-wide associations for psychotherapy) from 41 European countries, and more than 120,000 psychotherapists. Membership is also open to individual practitioners.

Based on the Strasbourg Declaration on Psychotherapy of 1990, the EAP opts for high training standards for a scientifically based approach and stands for a free and independent practice of psychotherapy in Europe. In an attempt to establish a mutual recognition and equal conduct of psychotherapy in this part of the world, it has established a European Certificate for Psychotherapy (see the section below on training and accreditation in European countries). The EAP has also developed ethical guidelines for the protection of clients, which are obligatory for its members.

ADPCA

The *Association for the Development of the Person-Centered Approach* (ADPCA) welcomes the participation of educators, therapists, psychologists, psychiatrists, nurses, social workers, health service providers, pastoral counsellors, organization development specialists and all people who are interested in the field of human relations and personal and interpersonal development. The association sponsors an annual conference, a distinctive feature of which is large community group meetings, and disseminates information about other person-centred activities and organizations throughout the world. It publishes a newsletter, a journal and an annual membership directory.

Journals and bibliographies

The most important international journal since its inception, in 2002, is the journal of the WAPCEPC: *Person-Centered & Experiential Psychotherapies* (*PCEP*). The mission of this peer-reviewed journal, which is published four times per year by Routledge/Taylor & Francis, is to create dialogue among different parts of the person-centred and experiential tradition; to support, inform and challenge fellow practitioners and theorists; to stimulate creativity; and to impact on the broader professional, scientific and political context.

Since 1994, the ADPCA has also published *Person-Centred Review*. Currently, one volume of this journal is produced per year.

Alongside these journals, there exist some other international journals such as *The Folio* (journal of the Focusing Institute) and *International Pre-Therapy Review*, which are directed at more specific branches of the person-centred family.

National journals in the person-centred field with an international relevance include:

- *Person-Centred Quarterly* (newsletter of the BAPCA);
- *Gesprächspsychotherapie und Personzentrierte Beratung*, journal of the GwG (Germany);
- *PERSON* (the journal of the Austrian, Swiss and German associations);
- *Tijdschrift Cliëntgerichte Psychotherapie* (the journal of the Dutch and Flemish associations).

Bibliographies in the person-centred field are manifold. The two most well-known have been those of Germain Lietaer (Leuven University), regularly published throughout the years 1970–2000, and the German language-oriented reviews by Peter F. Schmid. Peter Schmid has also compiled complete reviews of Rogers' publications (Schmid, 2005). See the internet addresses towards the end of the chapter for further listings.

Research

Although research on person-centred and experiential therapies is flourishing again in all continents (see Chapter 31, and the chapter by Robert Elliott, Les Greenberg and Germain Lietaer, 2004, in the latest edition of *Bergin and Garfield's handbook of psychotherapy and behavior change*), not much international cooperation is going on. An

exception to this is the International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT). The goal of this international project is to improve psychotherapy and psychotherapy training in a broad range of theoretical approaches by encouraging systematic research in therapy training institutes and university-based training clinics. More specifically, it aims at constructing an agreed-upon common core protocol for evaluating therapy (training) outcome, utilizing practice-based research methods. Furthermore, it aims to carry out an international collaborative study of therapy (training) outcome in training institutes and clinics. Although this international collaboration is not restricted to person-centred and experiential trainings, some of the initiators and leading figures of the project are from this orientation (including Robert Elliott from Scotland, and Alberto Zucconi from Italy).

Robert Elliott is also one of the initiators of the Network for Research on Experiential Psychotherapies (NREP), a website devoted to the purpose of stimulating research on experiential/humanistic psychotherapies. This was founded to provide an overview of the whole range of experiential therapy research, including research on:

- client-centred/person-centred therapy;
- gestalt therapy;
- focusing-oriented psychotherapy;
- process-experiential psychotherapy;
- psychodrama;
- existential psychotherapy;
- emotion-focused therapy;
- expressive/arts therapies;
- basic experiential/phenomenological research on particular problems of living (for example, depression or trauma), which might help experiential therapists better understand their clients.

Students as well as experienced researchers can download instruments and protocols from the Network's website (www.experiential-researchers.org) and use them in dissertations and other studies.

Over the last decade, researchers (and politicians) have challenged the effectiveness of psychotherapeutic treatments by focusing particularly on evidence-based research in. In this respect, it is interesting to learn how person-centred therapies can become evidence-based (Takens, 2003; Van Doesum & Takens, 2011). Researchers such as Lietaer (2003) and Elliott (Elliott & Freire, 2008; see also Chapter 31) have concluded that person-centred therapies work and are as effective as cognitive therapies in different areas of treatment (Cooper, Watson, & Hölldampf, 2008).

Training and accreditation in European countries

With the unification of Europe, there has been a desire to make university training more comparable, compatible and exchangeable within the European countries. From this perspective, the NEAPCEPC had, as far back as 1990 (Minutes of the 4th

General Assembly of NEAPCEPC, Brussels, 2001), formulated a statement on the mutual recognition of (parts of) training for person-centred therapists by its members:

> In case of a change of residence completed trainings or individual components of trainings in Person-Centred Psychotherapy will be recognized reciprocally if:
>
> - the conditions for participation of the training as recognized by the association of the new country of residence are met and
> - the entire training or individual components of trainings are compatible with the training curriculum of the association in the new country.

The representatives of the boards of the associations further stated that 'the conditions of participation, the structures, the components and the content of their training curricula of person-centred psychotherapy are compatible to a large extent'.

About 10 years later, in 2001, a further step towards unification was made by agreeing upon common basic principles for person-centred and experiential training and further training in psychotherapy and counselling (Box 33.1). These principles meet the requirements of the EAP psychotherapy training conditions (Box 33.2) and underscore the Strasbourg Declaration on Psychotherapy of 1990 (Minutes of the 4th General Assembly of NEAPCEPC, Brussels, 2001), which states that:

> In accordance with the aims of the World Health Organization (WHO), the non-discrimination accord valid within the framework of the European Union (EU) and intended for the European Economic Area (EEA), and the principle of freedom of movement of persons and services, the undersigned agree on the following points:
>
> - Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
> - Training in psychotherapy takes place at an advanced, qualified and scientific level.
> - The multiplicity of psychotherapeutic methods is assured and guaranteed.
> - A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.
> - Access to training is through various preliminary qualifications, in particular human and social sciences.

According to the EAP, on 11th February, 2004, the European Parliament voted for the implementation of the profession of psychotherapists to become a harmonized profession within the whole European Union. This decision should in the future enable psychotherapists to work with the national diploma in all European Union countries. The training basis will be the guidelines of the European Certificate for Psychotherapy. As PCE Europe has been approved by the EAP as a European Wide Organization and a European Wide Accrediting Organization, membership of PCE Europe is an attractive option for organizations and institutes in the field of person-centred/experiential psychotherapy.

Box 33.1

Principles for person-centred and experiential training and further training in psychotherapy and counselling as formulated by the NEAPCPEC/PCE Europe (2001)

- Person-centred/experiential training and further training in psychotherapy and counselling is understood as the facilitation of personalization, that is, the development of the personality of the trainee, by a person-centred/experiential relationship and encounter between the trainers and the trainees aiming at the personal and professional abilities required to offer, establish, maintain and develop person-centred/experiential relationships with clients.
- It is an enterprise both orientated towards the process and experience as well as committed to a profound theoretical reflection of experiences.
- It consists of:
  - experience in self-development in different settings (for example training groups, personal development groups, group therapy or counselling, individual therapy or counselling, and so on)
  - dealing with the theoretical works of Carl Rogers and other person-centred and experiential theoreticians as well as the continuous development of the trainee's own theoretical stances
  - the concrete application of the conditions
  - supervised practice of person-centred/experiential relationships with clients.

Among other elements the theoretical learning consists of: anthropological, philosophical and ethical foundations, theory of personality and relationship development, both in general and regarding processes of different persons and groups in different situations, theory of psychopathology and therapy, contextual (legal, medical, economical, and so on) necessary knowledge.

- It is carried out in relationships with different facilitators/psychotherapists/counsellors/teachers and in various settings in order to profit from diverse learning possibilities, to foster creativity and to acknowledge personal and cultural diversity.
- It is committed to a self-guided way of learning on the basis of empowerment and the 'freedom to learn' as postulated by Carl Rogers and to self-evaluation while meeting the requirements within the respective given legal and institutional frames.

Institutions and persons providing training are committed to clearly defined ethical standards, a continuous scientific development of theory and practice of the person-centred/experiential approaches, to scientific research and to working together with similar institutions and persons on national and international levels.

Box 33.2

EAP psychotherapy training conditions

1. The total duration of the training will not be less than 3200 hours, spread over a minimum of seven years, with the first three years being the equivalent of a university degree. The later four years of which must be in a training specific to psychotherapy.
2. The training includes the following elements:
   2.1 *Personal Psychotherapeutic Experience*, or equivalent. This should be taken to include training analysis, self-experience, and other methods involving elements of self-reflection, therapy, and personal experience (not less than 250 hours). No single term is agreed by all psychotherapy methods. Any training shall include arrangements to ensure that the trainees can identify and appropriately manage their involvement in and contributions to the processes of the psychotherapies that they practice in accordance with their specific methods.
   2.2 *Theoretical Study*. There will be a general part of university or professional training and a part which is specific to psychotherapy. University or professional courses leading to a first University degree or its equivalent professional qualification in subjects relevant to psychotherapy may be allowed as a part of, or the whole of, the general part of psychotherapy theory, but cannot contribute towards the 4 years of specific psychotherapy training. Theoretical study during the 4 years of training specific to psychotherapy should include the following elements:
      - Theories of human development throughout the life-cycle
      - An understanding of other psychotherapeutic approaches
      - A theory of change
      - An understanding of social and cultural issues in relation to psychotherapy
      - Theories of psychopathology
      - Theories of assessment and intervention
3. *Practical Training*. This will include sufficient practice under continuous supervision appropriate to the psychotherapeutic modality and will be at least two years in duration.
4. *Placement in a mental health setting, or equivalent professional experience*. The placement must provide adequate experience of psycho-social crisis and of collaboration with other specialists in the mental health field.

Internet addresses

International organizations and networks

- World Association for Person-Centred and Experiential Psychotherapy and Counseling (WAPCEPC): www.pce-world.org
- Network of the European Associations for Person-Centred and Experiential Psychotherapy and Counseling (NEAPCEPC): www.pce-europe.org
- Association for the Development of the Person-Centered Approach (ADPCA): www.adpca.org
- Center for Studies of the Person (CSP): www.centerfortheperson.org
- Emotion-focused therapy (York University, Toronto, Canada): www.emotionfocusedtherapy.org
- The Focusing Institute (New York, USA): www.focusing.org
- Pre-Therapy International Network: www.pre-therapy.com
- Network for Research on Experiential Psychotherapies (NREP): www.experiential-researchers.org
- Person-Centred and Experiential Psychotherapy International Research Project (PCEPIRP): www.communityzero.com/pcepirp

Publications

Bibliographies

- The Carl Rogers Bibliography Online (by Peter F. Schmid): http://rogers.pfs-online.at
- The Carl Rogers Collection/Archive (University of California at Santa Barbara): www.oac.cdlib.org/dynaweb/ead/ucsb/rogers
- Primary bibliography of Eugene T. Gendlin (by Frans Depestele): www.focusing.org/gendlin/gol_primary_bibliography.htm
- The Person-Centered & Experiential Bibliography Online (by Peter F. Schmid): http://pce-bibliography.pfs-online.at
- Client-Centered/Experiential Psychotherapy and Counseling Bibliographical Survey (up until 2000) (by Germain Lietaer): www.vvcepc.be/page?&orl=1&ssn=&lng=1&pge=95.
- The International Archives of the Person-Centered Approach (IAPCA), edited by Alberto Segrera, containing internet access to references in Dutch, English, French, German, Italian, Portuguese and Spanish: www.uia.mx/aiecp

Journals

- *Person-Centered & Experiential Psychotherapies* (published by Routledge/Taylor & Francis): www.pce-world.org/pcep-journal.html
- The *Person-Centered Journal* (published by ADPCA): www.adpca.org/Journal/journalindex.htm
- *The Folio* (published by the Focusing Institute): www.focusing.org/folio.html
- *International Pre-Therapy Review* (published by the Pre-Therapy International Network): www.pre-therapy.com
- *Person-Centred Quarterly* (published by BAPCA): www.bapca.org.uk
- *Gesprächspsychotherapie und Personzentrierte Beratung* (published by the GwG): www.gwg-ev.org/cms/cms.php?pageid=5
- *Person: Internationale Zeitschrift für Personzentrierte und Experienzielle Psychotherapie und Beratung* (a German-language journal): www.personzentriert.at
- *Tijdschrift Cliëntgerichte Psychotherapie* (published by the VCgP & VVCgP; a Dutch-language journal): www.tcgp.nl/nl/index.htm

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