

SPECIAL ISSUE

ADPCA 2009

“Older and Growing”

EDITORIAL

It is a privilege to return to the editor's desk of *The Person-Centered Journal*. The current volume begins with an incisive treatise on person-centered communication between people with and without dementia by ADPCA 2009 preconference presenter Claudia Strauss. Following Strauss, ADPCA veteran and 2009 keynote speaker Edwin Kahn details an integrative model for understanding client self-concept development and therapy process. Kahn draws from person-centered, self-psychology, inter-subjectivity and relational psycho-analysis theories, and he evokes Redekop and Grant to respond with consonant and dissonant opinions, respectively. Stimulated by their responses, Kahn furthers his analytic person-centered rapprochement with the article, *Sandor Ferenczi, A Proto-Rogierian*. Volume 17(1) concludes with veteran therapist Jon Rose's case of client-centered therapy, in an integrated care setting, with a client with years of untreated PTSD.

Volume 17(2) commences with Fred Redekop's adroit examination of the practical limitations of the non-directivity paradigm, followed by Helen Hamlet's expert illustration of the core conditions as a foundation for school counseling practice. Next, Ian Mayes shows that Rogers' conditions are implicit in Nonviolent Communications training. Three outstanding student papers follow beginning with Debra Weikert's review of research on success and limitations of client-centered therapy (and therapy in general) with highly masculine and violent clients; Liz Eager's commanding overview of the six core conditions, Sarah Walker's *Inclusion as a Natural Extension of the Person-Centered Approach*.

Tremendous thanks to Kristina Angstadt, Layout Editor, and a special thanks to the authors.

-Jo Cohen Hamilton

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Alzheimer's and Authenticity: A Person-Centered Framework that Promotes Mutuality and Reciprocity

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I would like to address two aspects of engagement between people with diagnoses of dementia and people without such diagnoses.

The first includes the following observations:

- that conversations that satisfy both participants are conversations that flow
- that relationships are evolutionary in nature, not prescriptive
- that meetings of minds are best achieved when there are meetings of hearts
- that a sense of the other's essence, and the sense of valuing that essence, needs to be reciprocal for any of the first three to take place

The second sets forth these principles:

- that our *desire* to do the best we can often impedes our *ability* to do the best we can
- that setting limits tends to limit...and ricochet

This paper discusses how these two aspects intersect....and interfere with the efforts of those of us who lack diagnoses of dementia to sustain relationships with those of us who struggle with them—depriving each of us of joy, meaning, and deeper exchanges.

And the corollary—when these qualities of life are missing, we lose dignity, patience, peace, energy, which can lead us to lose will,

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disengage, become less effective at filtering, and less able to control impulses.

It is thus that the whole person sustains the whole person, and thus that *each* must experience *the other* as a whole person in order to experience being whole persons themselves.

Here are some examples of how this works and what we can do to participate in simpler, richer, and more easy-going interactions...and help others do the same. Though what follows is couched in terms of friend/family/co-worker interactions, principles and practice hold true for therapeutic interactions. As will become evident, planning these interactions to be therapeutic, even *conceiving* of them as therapeutic, can lessen the therapeutic outcome.

REACTIONS THAT RICOCHET

Clinging to Shifting Sands

A diagnosis of Alzheimer's tends to crystallize our need to hold on to what we have. This isn't true just for the person who has been diagnosed; it is true for friends and relatives. The sense of impending loss throws people off balance and makes them hold on tighter. This generates a set of behaviors that undermine the very goal those behaviors are directed toward: supporting the person with the diagnosis and continuing to enjoy a mutually rewarding relationship.

How does this happen? By confusing the extrinsic nature of the things we want most with their intrinsic nature. By trying to control everything that happens rather than adjusting to flow in accustomed ways. By taking on so much of the responsibility for a relationship that the other person no longer has a role.

Taking the Level out of the Playing Field

The need for purpose and control is universal. Without them, life loses meaning. In order to feel those things and be able to act on them, we also need self-respect and the respect of those around us. When their foundation rests on shaky ground, we are in trouble. That foundation depends on our sense of self and our connection with

others. These four elements—purpose, control, sense of self, feeling connected to other people—form the cornerstone of a healthy inner life and give life meaning.

Alzheimer's threatens that. When those of us *without* the diagnosis hold on too tight, we threaten it, too. The more level we can keep that playing field in our relationships with those struggling with that diagnosis, the more helpful we are to them and, paradoxically, the more we keep of the relationship we cherish.

How does this work?

Tangling Manner, Matter, and Mode

Change is the stepsister of Alzheimer's. It comes with the territory. When it comes to communication and relationships, though, we tend to change what we should keep constant, and keep what we should change.

We change the manner in which we present ourselves; we keep the matter and mode the same.

Here is why it should be the other way around...and how reversing that approach produces both better—and happier—results.

Manner

Manner conveys information without words. It includes body language, tone of voice, pitch of voice, rhythm of voice, intensity of voice, mood of voice, facial expression, posture, position of eyebrows, use of eyes. Most of us absorb these messages to a far greater degree than we do any words that are spoken; we give them greater weight, and the feelings they evoke stay in our memory longer.

Manner lets us know we are respected (or not), cared for (or not), seen as equals (or not), welcomed and appreciated (or not), giving mutually to the relationship (or not).

When manner and words are not in sync, we know something is off and we tend to listen to the nonverbal cues. With dementia, as language processing skills diminish, dependence on these cues not only

becomes much greater, it continues to increase. Those of us lucky enough not to have dementia need to keep that in mind.

Lack of respect is painful: it destroys trust; it hurts relationships; it depletes, disables, and damages. Lack of respect and parity go hand in hand. And this lack makes it so much more difficult to provide support because the essence of the person—that part that most needs support—can no longer accept it from those offering it. On the other hand, respect and mutuality are life-affirming; they promote positive feelings, energy, patience, activity, and self-actualization. When it feels right for the person with Alzheimer's, it feels right for the person without it. And there is the potential for connection, laughter, joy—the easing of burdens for both.

We don't change our manner when someone has a condition that is temporary (a broken leg, mono) or a disease that is chronic (arthritis, diabetes). We're matter-of-fact, supportive, joke around, maybe even pushy—but we still see them as peers, adult-to-adult, and that comes through.

If we adjust our perceptions, our manner will follow.

Matter

Matter is what we talk about. The best conversations leave both participants happy. They work because each is listening as well as talking, listening to the whole person and not just to the words. Sometimes we introduce a topic; sometimes the other person does. As in any successful interaction, we're guided by the person and the give and take.

We can do that and still keep the challenges of dementia in mind. When the topic is not about some business that needs to be transacted, the immediate goal for both parties is to find the interaction rewarding and pleasurable. The long term goal is for both parties to want to repeat the experience.

This means the matter doesn't matter. It's a device to create engagement, a means to connect two people in a meaningful way, a hook to hang the conversation on.

And matter doesn't have to be articulated. If what really matters is feeling one is worth talking to, and that the other person

enjoys one's company, it's no longer about the words. It's about spending time together.

Silence can be comforting, non-threatening, safe, even enjoyable. As Alzheimer's progresses, silent companionship can be relaxing, too. No need to negotiate all the pitfalls of language and memory; no need to risk messing up or trying the patience of the other person; no need to worry that the other person isn't having a good time. Both people in the conversation feel these things and worry about them. What if they didn't have to?

Don't be afraid of silence. When one person is comfortable with it, the other person will be, too.

Mode

Mode is how we put our sentences together. How we get the conversation going. How we keep it going. How we change direction. How we deepen it. How we end it. It's about the process we follow and the techniques we use. For most of us, it's set on automatic pilot.

Because of continuing changes in how someone with Alzheimer's is able to manage language and memory—both a big part of managing conversations—those of us without Alzheimer's need to take our conversational process off automatic and revert to manual.

We need to become aware of how much of the time we ask questions rather than make comments. And we need to examine the type of questions we ask. As dementia progresses, first the type of question and, eventually, just the presence of a question, can present problems and wound dignity.

The challenge of questions is that they demand a response. It doesn't matter who asks or how the question is constructed, or if one understands the question or not. We all recognize a question and hear the question mark at the end. We know that we are expected to answer. Not answering would be inappropriate, outside cultural norms, and embarrassing. Misunderstanding, and answering the wrong way, would be humiliating, too. If we have trouble processing language, accessing memory, or forming our own sentences, we will realize we are stuck. That's a horrible position to be in. How do we ensure we don't put someone else in it?

The key thing is to ask questions that don't require memory retrieval, are so commonplace that the answer is automatic, refer to a suggested activity and can be answered with a yes or a no, or don't require an answer at all.

Comments, for example, don't require a response. It is up to us whether we make a comment in return, pose a question, or just nod or smile.

By untangling the threads of manner, matter and mode, we enhance the possibility of entangling the bonds of connection, essence, and meaning, in all the best embodiments of that word.

Reorienting What Can't be Oriented

Clarifying confusion is engrained in us. We all need to make sense of where we are, what is happening, and how it affects us. It's the way we figured out how the world works, what we could expect to happen next, and how we might be able to control some of it. It was our primary job when we were babies and it's pretty compelling still. And we find it disorienting when the people around us aren't sharing the same present we occupy.

It is incredibly difficult not to wade in and *insist* that those around us acknowledge the same time and place we're living in.

If reorienting *once* were all it took, go for it. Sometimes that's the case. If it can be done without embarrassing or frightening the person, it's all good. However, if the information can't be retained for more than a few minutes, if the person is only going to be embarrassed and frightened and maybe even hurt again, it's not worth it. These emotions take energy, energy better used elsewhere. And sometimes the attempt to reorient only makes the person hold on tighter to their perceptions, to fight what you are trying to do, and it ends up taking longer to move out of that place.

Often, it is counterproductive. Sometimes it is damaging. Who among us wants to relive those moments when we first heard of the death of someone important to us, such as a parent? Who wants to relive it as if we had never lived it before, because we are living in a time before it happened?

Be prepared for the present to be *their* present. Joining them is validating and reassuring. How would we feel if the most basic of beliefs—our understanding of where we are and when we are—were challenged? How could we trust the person who insisted we were wrong? What would be easier: giving up what we know to be true or giving up our trust in the messenger?

REACTIONS THAT RESTORE

Keep in mind that:

- the more we try to control, the less control we have
- the more we feel respected, the healthier we feel
- the more our relationships feel reciprocal, the more we welcome them
- the more we concentrate on essence, the stronger the connection

The person with the diagnosis may not be able to articulate, engineer, or live by these principles. Those without the diagnosis, though, can make them inform their manner, their matter, and their mode. And everyone's lives will be made both easier and richer, even sweeter, in so doing.

This means being open to where an interaction goes, and not trying to push it in a planned direction. It means expecting the interaction to feel good and letting the other person feel that expectation. It means setting aside all distractions and creating a moment not bounded by time. It means thinking of the other person as an equal, so that voice, body language, and facial expression will all convey that. It means sharing the control of the conversation and, as much as possible, ceding control in whatever areas possible.

Doing otherwise gets in the way. *Thinking* otherwise gets in the way. Thinking is reflected in the doing. Rather than focus on what you do, the key is to focus on what you are thinking. Perception is everything. If you see a patient, a case, a resident—you are not seeing a person. A unique individual whose responses matter and who is seeing *you* as well as the *way you see him*. Perhaps the label is different—

perhaps the label is creative and new and still resonates as respectful, compassionate, and individualizing—in time all codifiers—all shortcuts—become labels. And labels generalize, collectivize, and, without meaning to, dehumanize. The category, in itself, *by* itself, distances you from the other person (and thereby distances the other person from you). Thinking of the person by name, as person first, disease process second, can change everything.

It can make it possible for us to give as well as to receive—for both the person without the diagnosis and the person with the diagnosis to give as well as to receive. When all the flow is one way, the recipient is diminished. One of the best ways to give—to provide support—is to welcome being the receiver. And to recognize all the opportunities for that as they arise. And then to express gratitude for the gift.

This levels the playing field, restores reciprocity, reverberates with the rhythms of strong relationships, and helps us join forces in walking shifting sands as we have other vicissitudes of life—with flexibility, mutual respect, and a come-what-may insouciance.

If we are not authentic, we will not be perceived as authentic. And if we are not authentic, our support will not bring healing.

NOTE: This paper grew out of a talk presented at the 24th Annual Conference of the Association for the Development of the Person-Centered Approach, held in June, 2009. It is based on extensive experience with and numerous observations of interactions between people living with diagnoses of dementia and people struggling to maintain relationships and be supportive. The writer is the author of *Talking to Alzheimer's* (New Harbinger, 2001).

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The Kinship between Self Psychology, Intersubjectivity, Relational Psychoanalysis, and the Client-Centered Approach

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Abstract. *This paper presents for client-centered therapists, unfamiliar with recent developments in psychoanalysis, an overview of three contemporary psychoanalytic approaches: self psychology, intersubjectivity theory, and the relational approach. Despite very important differences, there is some overlap between client-centered therapy and the three psychoanalytic approaches summarized. For example, for both client-centered therapy and self psychology the emphasis is exclusively on the therapist's empathic understanding, with minimal expression of the therapist's idiosyncratic subjectivity in the relationship. Although relational psychoanalysts are much more likely to express their idiosyncratic subjectivity in the therapeutic relationship, through self-disclosures, enactments, confrontations, etc., they do so with a respect for the patient's autonomy and freedom to take or leave what is offered. In contrast to orthodox Freudian psychoanalysis, this attitude of not imposing a therapist's (or anyone's) authority has always been a key value of the non-directive client centered approach. Some theoretical ideas of psychoanalysis (e.g. being aware of both the therapist's and client's organizing principles/transferences) have interested this author. Another purpose of this paper is a personal description of the author's development as a psychotherapist.* Keywords: relational psychoanalysis, self psychology, intersubjectivity theory, client-centered therapy.

Author note: Edwin Kahn, Ph.D., is professor emeritus in psychology at Queensborough Community College, The City University of New York, where he taught for 31 years. He has been a psychotherapist for over 30 years, and has written articles comparing the theories of self psychology, intersubjectivity, and client-centered therapy. He has also written on the concept of non-directivity. Early in his career, while at the Mount Sinai School of Medicine, in New York City, he was active in the then-emerging field of sleep research.

A version of this paper was presented as the keynote address at the 24th Annual conference of the Association for the Development of the Person-Centered Approach, Kutztown, PA, USA, June 17, 2009.

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I value and cherish the teachings of the client-centered approach for the ways it has enhanced the practice of psychotherapy and for how it seeks to influence ordinary people (non-clients) through social change. As I will explain, some of my therapeutic roots were in psychoanalysis, and in particular Heinz Kohut's self psychology. I continue to find aspects of the psychoanalytic literature to be intellectually stimulating, of historical interest, and in some respects this literature helped increase my understanding of the therapeutic process. I have observed, in email correspondences and in the literature (e.g. Frankel & Sommerbeck, 2005), when client-centered theorists critique psychoanalytic approaches they often cite out-of-date psychoanalytic references. Contemporary psychoanalysts have incorporated many of Rogers's ideas (without giving him credit) in their therapeutic work, which is a momentous change from the Freudian orthodoxy of the 1970s and earlier. Therefore, a primary purpose of this article is to present an overview of contemporary psychoanalysis for client-centered therapists who may be interested in learning more about this literature. I will do this by summarizing ideas from three contemporary psychoanalytic approaches: self psychology, intersubjective theory, and relational psychoanalysis. I will show that although the theories and terminology are different, the practice of client-centered therapy and self psychology, in important ways, are similar. Relational psychoanalysis, with its emphasis on the expression of the therapist's subjectivity through self-disclosures, enactments, confrontations, etc., differs significantly from the client-centered therapy. However, there is some overlap since both relational analysts and client-centered therapists respect a patient's or client's autonomy and freedom of choice with regard to any therapist input; that is, no authority or control is ever imposed on anyone. This attitude contrasts with the orthodox Freudian approach of earlier times, where analysts usually thought they knew the behaviors and beliefs that were right for the patient. A different purpose of this article is to describe some aspects of my ongoing development as a psychotherapist. Finally, I assume, in this paper, that readers are already familiar with the methods and theory of client-centered therapy.

On the Expression of the Therapist's Subjectivity (Therapist-Frame Responses)

Client-centered therapy, as practiced by Rogers and as continues to be today, is based on the therapist's empathic understanding, unconditional positive regard, and a non-defensive openness (congruence), as well as on a non-directive attitude (Brodley, 2005; Bozarth, 1998; Grant, 1990). With a non-directive attitude, the therapeutic focus is on understanding and valuing the client's subjective experience, as well as on prizing the client as a person. Any expression of the therapist's idiosyncratic subjectivity, or what Brodley calls "therapist-frame responses," is kept to a minimum. I will begin with a quote from Barbara Brodley which she wrote in an email correspondence shortly before her untimely death. Therapist-frame responses, then, refer to responses that depart from empathic understanding, such as therapist self-disclosures, interpretations, confrontations, advice, etc. Barbara said,

I think you are right, therapist-frame responses can have a big, and, to the client, important impact. I don't give that the weight you do, because I am aware of insidious side effects, such as the disempowering of the client as self-determiner, or the way such things give more power to the therapist in client's eyes, or just the fact that the therapist has temporarily stolen the process from the client. Still, I am not suggesting we never offer our own insights or ideas - just not systematically, and with awareness of possible side effects, even if they are not apparent (B. Brodley, email communication, June 7, 2006).

I deeply appreciate the non-directive attitude, and I feel attempting to master it has helped immensely to improve my listening skills. This attitude should be an essential element in the training of all psychotherapists. However, I feel a bit less concerned than Barbara about the "insidious side effects" of expressions of the therapist's subjectivity-- if these expressions are offered with no hidden personal

agenda by the therapist, and are presented in a tentative way, and within the context of unconditional positive regard and empathy. Grant (1990), in describing a “principled non-directive” attitude, emphasized the discipline, self-restraint, and training it requires. With this attitude, therapists respect the voices of their clients, and the clients’ “right to determine their path in life” (p. 82). Grant also wrote that non-directive therapy

...is a way of being, and not a method, because it allows the therapist to make novel, personal, unplanned responses. ... These spontaneous and nonsystematic actions must be understood as coming from someone in whom the attitudes are deeply ingrained (p. 85).

In this paper I present several examples of expression of the therapist’s idiosyncratic subjectivity. In two of the examples I suggested a different topic for the client to pursue during a session. The resulting exploration in this new area seemed to enhance the therapeutic dialogue. I believe these examples demonstrate the flexibility of client-centered therapy, when non-directivity is appreciated as both an attitude and a way of being rather than a set of limiting behaviors.

Several Differences That I Have Appreciated Between Psychoanalysis and the Client-Centered Approach

One difference between psychoanalysis and client-centered therapy is that psychoanalytic theory concerns itself with psychological development, while the client-centered approach deals more with the here-and-now. With this developmental interest, analysts are often motivated, through interpretations, to help patients gain insight into the past causes of their current behavior and attitudes. Another difference is that psychoanalysts ideally want to see patients multiple times per week and long-term (Safran, 2009; Stern, 2009), whereas Rogers, and contemporary client-centered therapists, usually allow the clients’ wishes to decide the frequency of contact. Perhaps, because of these more frequent meetings, the ways in which the two participants

influence one another (the countertransference and transference interactions) is often of greater interest to psychoanalysts. As noted, psychoanalysts predominantly work long-term and intensely with individuals, often people who are more affluent, while Rogers, starting from his early days in Rochester (Kirschenbaum, 2007), appreciated the need to help greater numbers of people through social change and group experiences. Rogers and others in the client-centered community, have brought the philosophy of the approach to areas outside of therapy, such as education, parenting, business, medicine and nursing, expressive arts, cross-cultural work, poverty, conflict resolution, peace projects, etc. Finally, I appreciate the democratic values of the client-centered approach (where the ADPCA organization for many years refused tax exempt status because it was morally opposed to labeling someone as President or CEO, an IRS requirement), in contrast to the hierarchical, and sometimes elitist tendencies (see Safran, 2009, pp. 100, 103, 113) of some of the psychoanalytic approaches.

My Personal Background

Before I review theory, I would like to comment about my personal background. For 31 years I was a full-time college professor, and for much of that time had a small, part-time psychotherapy practice. In the late 1970s I was teaching a course on Personality Theories, and I began to see similarities between the new ideas of Heinz Kohut and Carl Rogers' theories. So in order to get promoted I began writing articles comparing self psychology (Kohut, Stolorow, and others) with client-centered therapy, including a well-received article (Kahn, 1985), entitled "Heinz Kohut and Carl Rogers: A Timely Comparison," that was published by the *American Psychologist* and still read today. I am aware now that during the 1980s and 1990s I was good at writing theory papers, but my skills as a practicing therapist were still evolving. In 2001 I retired from college teaching, and for the past eight years I have focused on developing my competencies as a psychotherapist. Since retiring from academia, my readings in the psychotherapeutic field diminished, and I began reading a few novels instead. Also, during this time, I began to meet with a relational

psychoanalyst for my own personal therapy. I feel, in my sessions with him, that this analyst provided the three core Rogerian conditions; however, he made no claim to be non-directive. As a matter of fact, he seemed to disparage non-directivity as a helpful therapeutic attitude (relational analysts have little inhibition about offering input from their frame of reference--more on that later). However, as a result of my work with him, my skills as a psychotherapist seemed to improve; that is, I began to see clients for longer intervals, and my practice gradually filled up. The question occurs to me—in what ways was he helpful? Often I did appreciate his input, and when he was off the mark, I would tell him so, and then continue with my train of thought. His setting of boundaries for me and his professionalism (a strict 45 minute hour; minimal personal self disclosures) were useful to me in setting boundaries and being more professional in my work with clients. I certainly felt he liked me (even when I, infrequently, chided him for interfering with my process!), and understood me, and, actually, much of the time he was non-directive and an excellent listener. Also, maybe, tolerating some of his imperfections allowed me to tolerate some of my own.

My Developing Interest in Kohut and Self Psychology

In the 1970s I was introduced to Heinz Kohut and self psychology by the supervisor I had at the time, Marjorie Taggart White. Kohut was becoming very popular in New York City, and I became one of the founding members of a local organization, named the Association for Psychoanalytic Self Psychology (APSP), which is still going strong today. In 1980 I went to Boston and heard Kohut speak at the Fourth Annual Self Psychology Conference. He was very impressive, and I became smitten, listening very carefully to every word he spoke. He spoke with considerable feeling, was charismatic, and seemed brilliant, with a special knowledge of the mind, and, especially patients with injury-prone personalities. His writings on narcissism and vulnerable selves resonated with some of my own personal experiences. When Kohut described how a vulnerable self attempts to stimulate, soothe, or pull itself together with excesses in sex, aggression, drugs, food, or by other means (e.g. compulsive

jogging), he seemed to be describing aspects of my own functioning. He also wrote that rational appeals to such patients to utilize greater self-control are ineffective; it is *the gradual strengthening of the structure or cohesiveness of the self*, through empathic understanding, that enables the person to better control rage, inappropriate sexuality, or other behavioral excesses (Kohut, 1972/1978, p. 646; Goldberg, 1978, pp. 263-296). These ideas were very meaningful to me then, and still are.

My Gradual De-Idealization of Kohut

Through the 1980s and 1990s my allegiances gradually changed. I started attending client-centered meetings in the United States and internationally. I found that I was more comfortable at those meetings than at the more formal psychoanalytic conferences. At client-centered meetings, in addition to intellectual presentations, there were small group and large group or community experiences, and more friendly interactions among participants, all of which I found rewarding and satisfying (especially interesting were the large international community meetings, where people from different cultures intermingled in an experiential way). I found the hierarchical nature of the psychoanalytic conferences, where there were psychoanalytic “stars” (important speakers), an “inner group,” and “master classes,” unappealing to me. I developed lasting friendships with client-centered colleagues. I began watching videos of Rogers doing therapy, which Barbara Brodley generously sent to me, and came to appreciate more fully Rogers’s way of doing therapy, and him as a person.

Also, I began to see shortcomings in Kohut. Jerold Bozarth (1998) emphasized the revolutionary premise of Rogers’s theory, “namely that the total locus of control belongs to the client. It is the client who knows best and that it is the client’s way, direction, and pace that is freed by the relationship of unconditional positive regard through empathy (Bozarth, email communication, April 27, 2009).” Kohut, certainly, as an analyst, was extraordinarily empathic; however, in his therapeutic work, and as a teacher, he sometimes sounded like an expert (see, for example, his concluding remarks on “The Two

Analyses of Mr. Z” [Kohut, 1979, p. 26]). Aspects of Kohut’s personality, his growing stature in the analytic community (people would fly to Chicago from various parts of the world to have a consultation with him), and the orthodoxy of psychoanalysis in that era may have all contributed to his somewhat strict and austere presence. One of his patients described strongly ambivalent feelings after learning of Kohut’s death (Strozier, 2001, pp. 358-361). Kohut required him to have sessions four times a week (the “pure gold of psychoanalysis”), pay for missed appointments (even though he did considerable travelling for his business), and gave opinions about how much progress he was making and how much more therapeutic work he needed (Strozier, 2001, p. 358). After Kohut died, this patient, who was seeing him up to the time of his death, “was in anguish at the shock of losing someone who had mattered so much to him. But he also felt freedom. He was no longer responsible for having to turn his life over to somebody and keep that appointment and feel guilty if he missed it. Relief and anguish were equally mixed (Strozier, 2001, pp. 360-361).” Hopefully self psychologists of today are more flexible about frequency of contacts than Kohut was in his era of psychoanalytic orthodoxy.

Kohut was referred to as “Mr. Psychoanalysis” by his peers at Chicago Institute of Psychoanalysis, since for many years he taught psychoanalytic courses from an orthodox Freudian perspective (Strozier, 2001). I have come to believe that Kohut took Rogers’s ideas on empathy and the self, and without giving him credit, incorporated these concepts as the core of self psychology (Kahn, 1996; Kahn & Rachman, 2000). Kohut and Rogers were both at the University of Chicago at the same time (1945 to 1957), and Kohut was clearly aware of Rogers’ new ideas. However, he described Rogers’ work with considerable disdain, and an air of psychoanalytic superiority (Kohut, 1973/1978, pp. 523-525). When comparing what was obviously client-centered therapy to the work of a general repairman who managed to fix an old alarm clock of his by just cleaning it, Kohut (1973/1978) said,

I think that my so-called watchmaker had a higher percentage of successes and knew more about what he

was doing than most of the psychotherapists who borrow one or the other insight or technical rule from psychoanalysis and apply it without understanding (p. 525).

It is ironic that Rogers, with his openness and non-defensiveness, as well as for his respect for the autonomy of each individual client, understood the process of therapy quite well. I do not wish to diminish Kohut's enormous contributions (he helped humanize psychoanalysis), but it was self-serving of him to dismiss and refuse to credit Rogers for his earlier seminal contributions on the therapeutic benefits of empathic understanding.

Kohut's "Selfobject" Concept and His Focus on the Patient's Subjectivity

Kohut's theory of "selfobject," and "selfobject transferences," has been one of his most important contributions. A selfobject is the experience of another person who is completely attuned to the needs of one's "self." Besides being empathic, a selfobject can be "mirroring" (the "gleam in the mother's eye"), and/or is a source of "idealization," that is, the parent or therapist, is experienced by the child or patient as a flawless idealized other. Kohut also described a twinship selfobject, which is the experience of another person as essentially like oneself, a human among humans. Selfobject experiences enhance vitality (Fosshage, 2003), and improve self-regulation and self-esteem in a child or patient. When a client-centered therapist is optimally providing the three core Rogerian conditions, it may be assumed, in Kohut's terminology, that the therapist is serving a selfobject function for the client. Therapeutic growth, for Kohut, consisted of the slow internalization of this selfobject function. Using a different language, stabilization of self-esteem and personal growth is surely facilitated from internalization of unconditional positive regard and empathic understanding in client-centered therapy. It is also important to emphasize that contemporary self psychologists have changed considerably (even from Kohut's thinking); they now believe that just being empathic is more helpful therapeutically than insight from

interpretation (Gill, 1994). In the above ways there is considerable similarity between self psychology and the client-centered approach.

One additional similarity between the two theories is that self psychologists, just like client-centered therapists, focus mostly on the patient's experiences, and seek to avoid the expression of the analyst's subjectivity. For example, Goldberg (1986) said, self psychology "wishes to minimize the input of the analyst into the mix. ... It is not minimized merely to keep the field pure so much as to allow a thwarted development to unfold. ... [I]t is based on the idea of a developmental program (one that may be innate or pre-wired if you wish) that will reconstitute itself under certain conditions (p. 387)." This innate or pre-wired developmental program sounds very much like Rogers's actualizing tendency.

Stolorow's Intersubjectivity Theory

Robert Stolorow and his associates (Stolorow, Atwood, & Brandchaft, 1994), in the 1980s, began building on Kohut's work by articulating a two-person, "intersubjective" approach. In orthodox Freudian psychoanalysis of the early and mid-20th century, the analyst's involvement in the relationship was minimized, and the blank screen analyst was abstinent, neutral, detached, and objective. With this shifted interest to the interaction of two subjectivities, emphasis was placed now on the analyst's contribution to the relationship. Stolorow (1994) wrote, "The impact of the analyst and his organizing activity on the unfolding of the therapeutic relationship itself becomes a focus of analytic investigation and reflection (p. 222)." Infant research further demonstrated the bidirectionality and mutual influence of the intersubjective field (Stern, 1985). For example, a child's capacity for self-regulation is based, not on the child alone, but on the child-caregiver system of mutual regulation (Beebe & Lachmann, 1988, 1992).

Stolorow theorized that "organizing principles," which develop from child-caretaker interactions, come to influence, in important ways, adult functioning. Daniel Stern (1985), with his concept of RIGs (representations of interactions that have been generalized), demonstrated how these organizing patterns form in early

development. These organizing principles are related to Piaget's concept of cognitive schemas, and may reveal themselves in the therapeutic interaction as the transferences (Kahn, 1987) of **both** the patient and therapist. Organizing patterns become problematic during childhood from selfobject failure, that is, faulty family interactions. The concept of selfobject failure seems similar to, and is, perhaps, a more inclusive concept than Rogers's "conditions of worth" (see Warner, 2009, for a discussion of limitations of the conditions of worth concept). Therapeutic change, for Stolorow, comes from positive relational experiences with the analyst, leading to the formation of new, healthier organizing principles, and from increased reflective self-awareness. Stolorow & Atwood (1992) wrote,

Successful psychoanalytic treatment, in our view, does not produce therapeutic change by altering or eliminating the patient's invariant organizing principles. Rather, through new relational experiences with the analyst in concert with enhancements of the patient's capacity for reflective self-awareness, it facilitates the establishment and consolidation of alternative principles and thereby enlarges the patient's experiential repertoire. More generally, it is the formation of new organizing principles within an intersubjective system that constitutes the essence of developmental change throughout the life cycle (p. 25).

Self psychologists have also described how the rupture and repair of the relationship is another important source of therapeutic change (Fosshage, 2003, p.434; Wolf, 1988). Rupture consists of the minor misattunements of the analyst, which are inevitable, and repair might be an apology or an empathic response to the patient's needs. Rupture and repair constitutes a "corrective emotional experience" (Kohut, 1984, p. 78), which contrasts with earlier experiences with family, where there was rupture and more rupture, and no repair.

In different respects, Rogers work preceded many of the "new" developments in psychoanalysis. For example, in contrast to orthodox Freudian psychoanalysis of that era, Rogers, in the mid-

1940s, while at the University of Chicago, anticipated the development of intersubjective psychoanalysis. With the influence of two of his graduate students, Oliver Bown and Eugene Streich, Rogers described the “therapist as entering into the relationship in a much more full and personal manner” (Raskin, personal communication, August 30, 1995). Rogers’ dialogue with Martin Buber, in 1957, on “I-thou” interactions, further contributed to his emphasis on “real reciprocity” in relationships (Thorne, 1992, pp. 69-70, 83-84).

Relational Psychoanalysis

At the time Stolorow was expanding on Kohut’s writings, a separate intersubjective approach was establishing itself, called relational psychoanalysis. Stephen Mitchell and other mostly American psychoanalysts contributed to the development of this relational approach (Skolnick & Warshaw, 1992). These theorists were influenced by the interpersonal psychoanalysis of Harry Stack Sullivan, and British object relations and feminist theories. The relationalists emphasized the therapeutic use of the analyst’s countertransference. Countertransference, as Racker (1968) noted earlier, was no longer considered a therapeutic error or a sign of personal flaws, but rather pervasive and inevitable, and “an invaluable source of therapeutic understanding (Wachtel, 2009, p. 167).” As a result, for the relationalists, there is a greater expression of the therapist’s subjectivity, and confrontations between the analyst’s and the patient’s subjectivities, which were labeled “enactments,” are not avoided. As can be seen, the relational approach differs substantially from client-centered therapy.

Bromberg (1991), in describing the relational approach, said,

I take as axiomatic a view of reality as structured through the active interplay between two people with independent centers of subjectivity. The analyst's perception of his patient (his “knowing”) is offered to the patient not as a corrective to the patient's faulty or distorted view but as a subjective impression to be

explored for its wrongness as well as for its compatibility with the patient's own experience (p. 435).

Bromberg (1989) also wrote,

...nor are confrontations systematically avoided as “failures” in empathy. ... For characterological growth to occur the patient must be able to see himself through the eyes of the analyst as an ongoing aspect of feeling himself validated and understood in the terms he sees himself (p. 277).

“Other-Centered Perspective”

James Fosshage (1997, 2003) labeled the offering of the analyst's perception of the patient, as described above by Bromberg, an “other-centered perspective,” and contrasted it with self psychology's “empathic listening perspective.” The other-centered perspective refers to what it feels like to be the other person in a relationship with the patient. Fosshage (2003) wrote, we can “experience a patient as hostile, controlling, loving, or appealing. ... This information about the patient and the interaction ... informs us about how the patient impacts others and about the patient's patterns of relating (pp. 422-423).” Fosshage (2003) added, “the disadvantage of using the empathic mode exclusively ... is to deprive a patient of direct feedback on how others may experience the patient, potentially reinforcing a solipsistic world (p. 423).” (Solipsistic is defined as being self-centered, egotistical, or narcissistic.)

There seem to be two distinct aspects of Fosshage's “other-centered perspective,” that is, one may either challenge a flaw or shortcoming, or, on the other hand, express genuine appreciation of the desirable aspects of the patient's personality. Obviously, the confrontational aspect of the other-centered perspective is always conveyed in the context of mutual trust and respect for the patient. There is the danger, however, that such comments may be a subtle or unconscious expression of the therapist's anger or disappointment with a patient (Stolorow, et. al., 1987, p. 114). In contrast, the honest

expression of appreciation of the positive qualities of a patient should be unequivocally helpful (Yalom, 2002, pp. 13-16). I will present such an example at the conclusion of this paper (see p. 21).

“Enactments”

Enactments, described as dramatic engagements of “mutually unconscious influence between patient and analyst (Aron, 2003, p. 627),” are of special interest to the relationalists. Aron (2003) wrote, “enactments constitute especially challenging moments for the analyst and may be decisive turning points in the analysis. These ... are times of high risk and high gain for both patient and analyst (p. 625).” And Bass (2003) commented, “enactments often rest on mistakes, slips, and blind spots that serve as doors through which the analyst and the patient are transported into realms of personal encounter and self-experience that might otherwise remain inaccessible (p. 661).”

Shumsky and Orange (2007), discussing enactments from a self psychology perspective, wrote, “surely all psychotherapists experience heightened or ‘dramatic engagements’ with at least some patients (p. 184)”. The authors describe an unintentional enactment (“Our First Fight”) which happened with one of Shumsky’s patients. This conflictual interaction occurred at the end of a long therapeutic day, where the patient’s complaints triggered an area of vulnerability in her therapist. The patient, who had been seen for years, was injured by the therapist’s unempathic, confrontational remarks, but came to see the truth in them, and the relationship, after the rupture, was repaired. Shumsky and Orange write that

...in some clinical situations this struggle to make a place for the analyst’s authentic participation may well succeed in generating vital new relational experience. But, with other patients needing validation and mirroring it might just as easily create a power struggle leading to an unyielding impasse or a treatment destroying negative therapeutic spiral (p. 185).

Rather than highlighting the dramatic moments of an enactment, Shumsky and Orange “emphasize the healing power of sustained, ongoing, attuned mutual regulation” that can be helpful over time (p. 190). Shumsky and Orange also, with some humor, reported that someone (reference lost) used a gardening metaphor to capture the difference between the self psychologists and the relationalists. The self psychologists (and, I should add, client-centered therapists) emphasize the watering aspect of the growth process while the relationalists, the weeding aspect (p. 188).

I will present an example of an enactment in my work with a client. A female client came to her session and began to describe a situation where she irrationally blew up angrily at her boy friend at a party. As I listened to her vivid description I started to become tense and uneasy inside, sensing her anger, and aware if I said the wrong thing I, too, might be the target of her hostility. A level of tension built up in me where I had to express what I was feeling. I said to the client, “I am feeling tense inside and am aware that I am frightened of your anger.” She heard my comments without criticism. Then I had another feeling, that in her anger I sensed her considerable power and strength. I shared these feelings with her as well. As we continued to communicate she spontaneously reported that these intense (at least for me), genuine two-person interactions were important for her, and that this interaction motivates her to come back each week. With most clients I spend most of sessions listening empathically, but this client has evoked emotions in me, maybe because of my own vulnerabilities. For whatever reason, she reports that these emotional interactions, which have never escalated into hostility, have been helpful. More recently, while describing other hostile outbursts she had, I have felt more comfortable listening, without fear of her anger toward me.

It is also of interest that in New York City we have a leaderless experiential group of client-centered psychotherapists that meets monthly. We have been meeting regularly with mostly the same people for some years now, and have developed strong attachments to one another. The participants express considerable empathic understanding toward one another in the group. However, not rarely, confrontations do occur, which include deep conflictual interactions among members. These encounters can be labeled enactments. It

seems that at times of these enactments, a more profound experience is occurring for the group. Deeper layers of the personality seem to emerge during these encounters. And in this group situation, they seem to be very helpful, perhaps because of the group's empathic responses to the individual members who are in conflict. It would seem that in a supportive group, with people who are not too vulnerable, confrontation, at times, can enhance the depth and meaningfulness of the participants' experiences.

“Transference”

While seeing clients, I rarely think about the psychoanalytic concept of “transference.” However, when clients, for no reason that I have precipitated, evoke feelings of anger in me, I find transference to be a valuable concept. I have been meeting with an intelligent man in his 40s, who, over time, began acting in ways that angered me. For example, he once came very late, saying he went to the gym instead of coming to the session as scheduled. At other times he didn't come and didn't call to cancel or left unclear voice mail messages, so I didn't know whether he was coming or not. Also when he did come, he repeatedly arrived late. I knew that this client was often hurt by important people in his life, including his parents, his older brother, and women, in different romantic relationships, as well. I thought to myself that he was attempting to hurt me and disregard me, as he had been hurt and abandoned. Recognizing the client's “transference” helped to sustain my empathic understanding, and allowed me to modulate my considerable frustration at his actions. On several occasions I said, “You seem to be treating me badly just like important others have treated you.” I doubt that this interpretation was particularly helpful, but it offered me a ray of hope that I would be treated better in the future. It would seem that in certain situations, and especially with clients who have issues with anger, that the concept of transference can serve to enhance the therapist's empathic understanding.

I will describe one other example where the transference concept seemed useful. The client, a woman in her 20s, loved and was very dependent on her older husband, while in different ways he

treated her poorly. For example, his business trips became longer than planned, and there was some evidence that he was unfaithful. Over time, and at his urgings, they separated. After separating, as she interacted with other men, a theme of her passivity became apparent in these new relationships. Also for many months she was avoiding filing for divorce, even though her husband showed no interest in saving the marriage. In one of our sessions she was looking at me dependently and wistfully, with longing eyes, as she had on some occasions before, for answers about what to do regarding the divorce. I felt, from her look, as if she were surrendering her personal power to me. I said, “It seems as if you have become dependent on me, as you were with your husband, and in other relationships as well.” This transference interpretation seemed to have an effect, since in subsequent sessions she more readily acknowledged her dependency needs with her husband, the men she was now dating, and even me.

Different Clients with Different Needs

Will one method of therapy work for all patients or at different phases of work with a particular patient? Bromberg (1989), in describing his interpersonal approach, refers

...to its fundamental commitment to the process being shaped by who the specific individual is as a human being rather than by its theoretical assumptions It would therefore be antithetical to interpersonal analysis to consider any analytic stance—including the empathic/introspective stance of self psychology—as facilitative to all patients (pp. 282-283).

Kohut (1981/1991) described severely traumatized patients, who, “for many years ... need an empathic understanding on the closest level that we can muster (p. 534).” Such patients, according to Kohut (1984), require very long periods of just understanding or attentive silent listening—they cannot yet tolerate the otherness, separateness, or foreignness of the therapist (p. 105, p. 177). Garry Prouty’s (1994) pretherapy with long-term psychotic and mentally

retarded clients involves repeating exactly what the client says without variation. This technique illustrates, with those extraordinarily vulnerable clients, how desperately they need validation. On the other hand, higher functioning individuals, whose sense of self is more stable, cohesive, and mature, who perhaps have been in therapy for a longer period of time, may appreciate occasional expressive input from the therapist's frame of reference. Bohart (1998) described such a client, a colleague of his, who wanted her therapist "to argue with her, debate with her, express opinions, suggest techniques, and so on, *while* respecting her self-directed growth process and autonomy" (p. 69).

Psychotherapeutic Discipline and the Need to Sometimes "Throw Away the Book"

Irwin Z. Hoffman (1998) has described various dialectical interactions, such as the one between psychoanalytic ritual and the spontaneous participation of the analyst. According to Hoffman, within the context of adhering to therapeutic discipline, it can be helpful, once in a while, to "throw away the Book." Hoffman (1998) writes,

The patient might view the analyst as content to sit back and pat him- or herself on the back for doing 'the right thing,' according to whatever the Book requires, at the expense of attending in a creative way to the patient's needs. Alternatively, or simultaneously, the patient might view the analyst as fearful of any kind of personal engagement (pp. 195-196).

Hoffman adds that "when the patient senses that the analyst, in becoming more personally expressive and involved, is departing from an internalized convention of some kind, the patient has reason to feel recognized in a special way." (p. 195)

Nat Raskin (1978/2004), from a client-centered perspective, has also expressed a need to break from convention, and thereby "throw away the Book" (see especially, p. 112). Raskin wrote that Bown, Streich, Rogers and others came to appreciate "that the person

of the therapist must be expressed in the therapeutic process and my own greater ability to do this (p. 104).” And he added, as a result of being a client in Gestalt therapy and a participant in peer groups, “I have learned to overcome my inhibitions—to cry, to get angry, to love. And I have been able thereby to enrich my practice as a therapist (Raskin, 1978/2004, p. 115).”

I conclude with three brief clinical descriptions where I “threw the Book away,” and departed from an empathic listening stance, and, in two examples, suggested a different topic for the client to explore. After 12 sessions with a 20 year old college student, who repeatedly spoke of her insecurity in class and with guys that she met, I began to experience our relationship as being somewhat superficial, and perhaps a bit boring. To engage more fully, I asked if she would be interested in talking about her family life. When she responded “Yes,” I asked, “How well did your parents listen to you?” After 12 sessions of listening to her talk uninterruptedly about her various insecurities, that question seemed relevant. She then said dramatically, “They never heard me at all!” This statement, the most profound uttered until then, opened up an exploration of some central issues, including gross misunderstandings between her and her parents while growing up, and a truly horrible experience with a psychiatrist during that time. From this probe, what felt like a superficial relationship changed into a more meaningful, honest therapeutic relationship, with greater mutual appreciation.

A high functioning woman who I had been meeting with for some time came to her session and began talking about her successful career, her tentative vacation plans, an interaction with a friend, and other, what I experienced as, chatty topics. I realized I was not connecting with her, and I began to think she was avoiding talking about what she described at our previous meeting, which, I must also admit, I was curious about. Finally, about half way through the session, I asked, “Well, what about that journalist who was attracted to you that you mentioned with interest the last time you were here?” The second half of the meeting became much more meaningful and genuine. Our connection was restored, and she spoke openly about her fear of falling in love with this guy, losing him, and her past hurtful, sad and very disappointing relationships. I believe that if I had

just stayed with her process, the session would have been wasted, and we would not have gotten to this deeper level. Her relationships with men is a particular current area of vulnerability for her, we both know that, and a mutual trust has developed which allowed us to explore her feelings about this topic.

I end with a anecdote where I departed from an empathic stance, and complimented a client, which is an example of Fosshage's (1997, 2003) "other-centered perspective." In the context of her description of very hurtful and unjustified remarks from her mother, I said to a client that she seemed very likeable to me. I didn't give much thought to my expression of genuine feelings, and she didn't seem to react in the session. However, at our next meeting she reported that she was deeply affected by it. She said after the session ended she went to her car and began sobbing uncontrollably for several minutes, and her feelings continued during her long drive home. My honest appreciation, which she rarely had from her insensitive parents, triggered these tears of bittersweet joy. This incident reminds me of the interview of Rogers with Gloria, when Rogers spontaneously said to her "You look to me like a pretty nice daughter." Gloria seemed briefly taken aback by Rogers's words at the time, but I wonder (disagreeing with Frankel and Sommerbeck, 2005, p. 49; 2008) if genuine appreciation of a client cannot be anything but helpful.

Conclusion

In this paper I have presented an overview of self psychology, intersubjective theory, and the relational approach with the goal of providing client-centered therapists with a summary of some recent developments in contemporary psychoanalysis. I have also described some aspects of my personal growth as a psychotherapist, including my idealization, and then gradual de idealization of Heinz Kohut and self psychology. As a therapist I have found some of the theoretical concepts of psychoanalysis helpful, such as "organizing principles," "transference and countertransference," and "strengthening the structure and cohesiveness of the self" through empathic understanding, even though I rarely think about those concepts as I work with clients.

In spite of differences in method and theory for each of the psychoanalytic approaches summarized, and between those approaches and client-centered therapy, there is some overlap between contemporary psychoanalysis and client-centered therapy. For example, both client-centered therapy and self psychology attempt to keep expressions of the therapist's subjectivity to a minimum. Although relational psychoanalysts willingly express their unique subjectivity to patients, they do so with a respect for each patient's freedom to use or discard what is offered. Client-centered therapists are much less likely than relational analysts to confront, make interpretations, or make self disclosures. However, when a client-centered therapist does self-disclose, he or she does so with a non-directive attitude, that is, with an appreciation of the client's freedom to take or leave what is offered. In respecting the individual client's or patient's freedom of choice, there is a similarity between the client-centered and relational approaches.

In the worlds of client-centered and psychoanalytic therapy there has been a lack of appreciation and understanding of the other discipline's contribution and efforts. American psychoanalysts, in general, have rarely appreciated Rogers's contributions, which have been dismissed as superficial and simplistic, while client-centered therapists fault psychoanalytic work by citing writings from the very orthodox, detached Freudian approach of the past. Rogerian theory, in many respects, is simple, but enormously profound, and many of his ideas have been incorporated in contemporary psychoanalysis. For example, Magid (1996) wrote,

I think it is ironic that much of what has come to be thought of as progress in psychoanalysis has in fact been the result of subtraction from, rather than addition to, our theories. As analysts we have increasingly learned to get out of our patients' way. (p. 626)

Along with empathic understanding, unconditional positive regard, and a non-defensive openness, getting out of the clients' way is just what client-centered therapy is all about.

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Teaching Us a Thing or Two: Kahn on Psychoanalysis and Rogers

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Both Freud and Rogers displayed unbending commitments to what they saw to be central to their life and work: Freud's dogma, his "monotony of interpretation" (Jung, 1989, p. 152), was sex; Rogers insisted on the idea that "*all individuals have within themselves the ability to guide their own lives in a manner that is both personally satisfying and socially constructive*" (Kirschenbaum & Henderson, 1989, p. xiv) without outside coercive strategies and directive interventions. However both were surprisingly flexible in theory and in practice—there was the Freud who, in treating the poet Hilda Doolittle, dropped the blank analytical mask and complained that she acted as if she didn't love him (Doolittle, 1956), and the Rogers who could be much more active and confrontational in encounter groups (Rogers, 1970). Since their deaths, the development of psychoanalysis and client-centered therapy has been in the general direction of greater flexibility rather than stricter dogma. Both have continued to evolve well beyond what their founders could have envisioned, and as Ed Kahn's (2010) paper reminds us, we need to periodically update our reference list so that we aren't constructing arguments involving outdated theoretical versions of these approaches.

Kahn (2010) provides a personable and knowledgeable tour of some of the new varieties—self-psychology, intersubjectivity, and the relational approach—that have been bred out of the old stock of Freudian psychoanalysis. As he does so, he plots his own development; Kahn does so in a refreshingly candid manner, talking about his faults and deficits, and being "freely and deeply himself, with his actual experience accurately represented by his awareness of himself" (Rogers, 1957, p. 97). Kahn's paper, then, provides a good comparison/contrast of contemporary approaches to psychoanalysis and client-centered therapy for clinical and educational purposes, as

well as insight into the journey of an educator and practitioner from the 1970s to the present.

In teaching counseling theories, I joke with my students that if I'm asking for the name of a theorist and they don't have any idea who it is, they should just guess Freud or Rogers and they'll have a 50-50 chance of getting the answer right. It's a joke—but only just. The most vital clinical issues oscillate between the two: the central importance of the client to each theory and how there were clients who could be considered partners in the founding and development of psychoanalysis and client-centered therapy (e.g., Anna O. and Dora and Little Hans; Herbert Bryan and Miss G. and Gloria); the therapeutic relationship and what the client and the therapist think and feel about each other; the central role each played personally in the development of their approaches (e.g., Freud's interpretation of his own dreams; Rogers' description of "becoming a person"), and so on. Teaching in general from a common factors perspective (e.g., Duncan, 2002), I focus mainly on the aspects of Freud's and Rogers' theories that foreground the client and the therapeutic relationship, and I am appreciative of the way Kahn helps us to update psychoanalytic understandings of the client's self and the client's and therapist's relationship, while continuing to compare and contrast these understandings with a client-centered approach.

As an educator, then, I can use Kahn's (2010) paper to describe the ways these approaches have continued to communicate with each other; for example in the work of Kohut, whom Kahn convincingly describes as borrowing from Rogers without giving credit in developing self psychology, and in the idea that Rogers anticipated intersubjective psychoanalysis, as he developed more and more of an interest in being fully real and authentic in all the relationships in his life. Kahn's paper provides more reasons for students of counseling and psychotherapy to continue to fully immerse themselves in the history of their field, since without knowing what Freud and Rogers originally said to one another (metaphorically speaking), we might not be able to follow the conversation today.

Kahn's (2010) paper accomplishes a deeper educational purpose of conveying an authentic and open attitude toward clinical theory and experience. He is open to the surprising finding that his

relational analyst provided Rogers' core conditions but also freely offered his idiosyncratic frame of reference (rather than suppressing it), and that this (somewhat directive) analyst helped him personally and professionally. He non-judgmentally describes his idealization of Kohut, followed by a gradual de-idealization, and says that he still finds many of Kohut's ideas to be worthwhile. He concludes that Rogers' lessons are simple but profound, and that often the best thing to do with clients is to just get out of their way. I could not agree more; there is much to be said for intensely meditating on a few of the most basic and profound lessons that have resulted from the ongoing conversations between Freud, Rogers, and others. I can imagine using Kahn's paper with my students to show how theory and one's experiences can combine to these kind of simple and profound moments, wherein we manage to step aside at the exact right time.

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Contemporary Psychoanalysis and Client-Centered Therapy: Different Practices

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Ed, I enjoyed your story of the development of your thinking about therapy. It inspired me to reflect on my story. Your contention in the paper that “there is some overlap between contemporary psychoanalysis and client-centered therapy,” however, is not part of your story. It is an intellectual claim. While I appreciated your story, I disagree with this claim. I will argue that your comparisons are not fair and their results not significant, because you fail to look beyond surface similarities in psychoanalytic and client-centered practices to compare how the practitioners of these therapies understand and justify what they do.

I don't address claims about similarities in theory (just to keep my response short and because I'm not much interested in psychological theories) or positions you take on other matters. I address only your two claims of similarities between the practice of client centered therapy and the practices of self and relational therapies. I take the liberty of limiting the scope of my response to what I am most interested in: therapies as ethical enterprises, human relationships that embody ideas about what is good or right to do.

Client-Centered Therapy and Self Psychology

Your one claim of similarity between the practice of client-centered therapy and the practice of self-psychology is that “for both client-centered therapy and self psychology the emphasis is exclusively on the therapist's empathic understanding, with minimal expression of the therapist's idiosyncratic subjectivity in the relationship.” Even if true, this amounts to little without evidence from writers on self-

psychology and client-centered therapy that they understand empathy and therapist self-expression in the same ways. You say only that both kinds of therapists *do* or “emphasize” the same things. But what do practitioners of each form of therapy *mean* by empathic understanding and expressing therapist subjectivity? What do they *intend* when they do them? How do they *justify* their practice of them? These are questions that reveal the “heart” of their practices, the meaning and ethical significance these practices have for their practitioners.

Practices may look very similar but be quite different in deeper and much more important ways. Breaking into one’s own home because one has forgotten one’s keys and breaking into someone else’s home to burglarize it have innumerable “important” or significant similarities. But the surface similarities they share pale in comparison to the much more meaningful differences we see when we look at what the owner and the burglar are doing as ethical enterprises, the living out and with notions of what’s good and right in human relationships, (Grant, 2004). If we understood the intentions, interpretations, self-understandings, values, and justifications of each, we would see of course that the actions of the owner and burglar are very different. We should seek to understand, evaluate, and compare therapeutic practices in the same way: on the basis of how practitioners understand and justify what they are doing.

Brodley (1999, 2006) argues that empathic understanding is an expression of the non-directive attitude inherent in Rogers’ core therapeutic attitudes, which are based on the value of respect for persons. Do self psychologists offer a similar line of reasoning to support doing empathic understanding? Brodley argues that the purpose of making empathic responses is primarily to check one’s understanding of what a client is getting at or trying to get at (Levitt & Brodley, 2005). Is this the purpose of empathic responses in self psychology? You wrote that “contemporary self psychologists. . . now believe that just being empathic is more helpful therapeutically than insight from interpretation.” Do they understand empathy and helpfulness in the same way client-centered therapists do? Brodley discourages making therapist-frame responses, such as self-disclosures or observations of the client, because of their risk of harm to clients and proposes guidelines for making therapist-frame responses based

on the value of non-directivity (Brodley, 1999). Do self psychologists echo this way of thinking in their writings?

On Client-Centered Therapy and Relational Psychoanalysis

Your one point of similarity between relational psychoanalysis and client-centered therapy practices is also based on an inadequate [editor's sic.] examination of the therapies. You claim that "in respecting the individual client's or patient's freedom of choice, there is a similarity between the client-centered and relational approaches." This respect consists solely of "a respect for each patient's freedom to use or discard what is offered." This feature is shared by many schools of therapy and does not indicate a special kinship between the client-centered and relational approaches (only some drug and alcohol treatments and old-fashioned psychoanalysis come to mind as exceptions). In any case, when this one similarity is seen in the context of the theories and values of client-centered and relational therapy, it has even less significance.

As you argue, "the relational approach differs substantially from client-centered therapy." One difference is that client-centered therapy is non-directive by design and the relational approach is directive by design. Another difference is that the practice of client-centered therapy consists fundamentally of the experience and expression of certain attitudes believed to be helpful and respectful of client self-determination (Brodley, 2002; Grant, 2004) and relational therapy does not. Relational therapists consider therapist-frame responses theoretically necessary for character change. Brodley (1999) argues that therapist frame responses should be rare, non-systematic, and consistent with the non-directive attitude. Both approaches may respect clients' freedom "to use or discard what is offered," but they differ radically in what and why they offer what they do.

Conclusion

Ed, I conclude on the basis of your depiction of self and relational psychoanalytical therapies that they have no significant similarities in practice with client-centered therapy. There's been some

intermarriage between psychoanalytic and client-centered schools over the years. You nicely show some of this mixing. But, at the level of the practices you discuss, no shared DNA is apparent. In my view, ethics are the heart of all therapeutic practices, and differences among practices should be articulated, defended, and challenged on moral grounds (Grant, 2004). An examination of the ethical views of client-centered and psychoanalytic therapies is the true test of kinship.

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Sandor Ferenczi, A Proto-Rogerian: A Reply to Fred Redekop and Barry Grant

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I want to express appreciation to Fred Redekop and Barry Grant for agreeing to take on the task of responding to my article. I begin my response by thanking Fred for his favorable review (Redekop, this issue, pp. 32). There is not much one can write when one receives such kind support. But to stir the pot a bit, I would like to elaborate on one aspect of Fred's review, by making a distinction between Freud the theoretician and powerful leader of the psychoanalytic movement, and Freud the therapist. During the past year I have taken a course on the writings of the pioneer psychoanalyst, Sandor Ferenczi. Ferenczi is well-known in the history of psychoanalysis since he and Carl Jung accompanied Freud on Freud's ground-breaking trip to Clarke University in 1909 to give the first lectures on psychoanalysis in the United States. Ferenczi was very close to Freud, went on vacations with him and his family, and there was a long and detailed correspondence between the two men. However, when Ferenczi began to articulate his own innovative ideas about therapy, by emphasizing the importance of therapeutic empathy, compassion, and love, he became alienated from Freud and other Freudian analysts (Breger, 2000, pp. 349-351; Rachman, 1989; Dupont, 1985). Ferenczi was accused of going too far in treating his patients with warmth and tenderness. However, Breger (2000) wrote, "these accusations were serious distortions of Ferenczi's sincere efforts to open himself emotionally to his patients' experience" (p. 350). It was some of Ferenczi's ideas, transmitted by his colleague Otto Rank, and Rankian social workers (Kirschenbaum, 2007, pp. 87-88), that made their way to Rogers in the 1930s, and influenced Rogers considerably. From reading Ferenczi's "Clinical Diary" (1932/1985), I have come to learn that Freud, brilliant as a theoretician and scientist, and powerful

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as a leader of the psychoanalytic movement, wasn't especially dedicated as a psychotherapist. Some of his own unexplored issues prevented him from being empathic with his patients. In 1897 Freud abandoned his seduction theory, came to believe that his patient's descriptions of sexual abuse were fantasies, and developed a more constitutional theory of instinctual drives and oedipal erotic wishes as the cause of neurotic suffering. It was Sandor Ferenczi (1932/1949), in his "Confusion of Tongues" paper, which was banned by the psychoanalytic community for many years, who asserted that real trauma, including sexual abuse, was often the cause of psychological suffering. Ferenczi (1932/1985) cared about his patients, wanted to be of help in relieving their suffering, was open and honest in the therapeutic relationship, and didn't want to exercise any power or control over patients. Freud's failure to understand his own early trauma, prevented him from giving serious consideration to the traumas of his patients. Breger (2000) wrote,

Working with Breuer's cathartic method had brought Freud too close to his own dissociated core of loss, anxiety, and helplessness. ... Though initially drawn to Breuer's cathartic method, he rejected it in favor of his theory of sexuality and his stance as the all-knowing therapist-authority because listening to the agonizing memories of loss and pain related by these patients rekindled his own perturbing memories. To empathize with them, to feel their losses and fears, was not a safe place for Freud; interpreting their sexual instincts and fantasies, and minimizing their traumas, was much more comfortable (pp.121-122).

Breger (2000) also wrote

Freud ... was committed to his universal theories and never conceived of psychoanalytic therapy in terms of empathy or dialogue. If patients did not agree with his interpretations, he considered it a sign of their resistance (p. 226).

Freud, innovative as a theoretician and scientist, and an ambitious and powerful leader of a movement, the aim of which was to understand mental life, was, however, limited as a practicing therapist (Dupont, 1985, p. xxiii). Apart from this one elaboration on Redekop's review, I very much appreciate his supportive comments regarding my manuscript.

I want to thank Barry Grant (this issue) for stimulating me to think in more depth about the non-directive attitude and my own practice of psychotherapy. Barry wants to make distinctions between different forms of therapy, and I want to find their commonalities and to integrate them. I am not sure that making distinctions between approaches is more desirable than articulating their similarities, and I imagine both may be helpful in different respects.

Of the various issues discussed in my article, Grant challenges my belief that the practice of client-centered therapy and self psychology are similar. He asks "what do practitioners of each form of therapy *mean* by empathic understanding and expressing therapist subjectivity? What do they *intend* when they do them?" He cites Brodley (1999, 2006), who "argues that empathic understanding is an expression of the non-directive attitude inherent in Rogers' core therapeutic attitudes, which are based on the value of respect for persons." He further writes, "Brodley discourages making therapist-frame responses, such as self-disclosures or observations of the client, because of their risk of harm to clients and proposes guidelines for making therapist-frame responses based on the value of non-directivity (Brodley, 1999)" (pp. 36-37 this issue). In Brodley's (1999) article she said, "a mean percent of over ten to twelve percent of therapist-frame responses (other than therapist-frame responses to clients' questions) ... probably casts doubt on the therapist's consistency in being client-centered" (Brodley, 1999, p. 25fn).

It is true that self psychologists never discuss the issue of non-directivity. However, I continue to believe that experienced self psychologists, just like client-centered-therapists, appreciate the need for empathic understanding, minimize the expression of their own unique subjectivity, and, to my knowledge, have no hidden agenda for the patient. A few years ago I taught a course on Kohut's writings at a self psychology institute. The emphasis for candidates at that institute

was on empathic understanding and limiting the expression of their framework in the relationship. I have quoted (Kahn, this issue, pp. 23) Shumsky and Orange (2007), who emphasize the “healing power of sustained, ongoing, attuned mutual regulation” that can be helpful over time (p. 190). I also cited Goldberg (1986, p. 387), who reported that self psychology “wishes to minimize the input of the analyst into the mix.” It is minimized “to allow a thwarted development to unfold. ... [I]t is based on the idea of a developmental program (one that may be innate or pre-wired if you wish) that will reconstitute itself under certain conditions.” This innate or pre-wired developmental program does sound very much like Rogers’s actualizing tendency.

I do agree with Grant that implicit in the tradition of self psychology, and psychoanalysis in general, is the role of the “analyst” as an expert, and this tradition may, in some subtle ways, impact what occurs in the consulting room. I will say more about this role of the “analyst” as an expert later.

Interestingly, some time ago, I spoke, on very separate occasions, to two different senior self psychologists, both women, in New York City. They both lived in Chicago early in their careers and each had an experience of client-centered therapy. Each said the same thing, that they found client-centered therapy superficial. Their experience seems to confirm the experience of Marge Witty (2004), when she noted,

If Barbara T. Brodley had not raised the issue of the distinctions between experiential and client-centered therapy, it is unclear to me whether a genuinely non-directive school of client-centered therapy would have survived.... At the time I took the practicum at the Chicago Counseling and Psychotherapy Center in 1972, client-centered therapy was taught in a highly oversimplified, shallow way as a kind of active listening. None of the staff at that time transmitted what I now understand to be client-centered therapy (Author Note, p. 22).

Regarding the issue of shallowness in the approach, Brodley (1999) said that over-consistency in the implementation of the therapeutic attitudes may be detrimental to the relationship (p. 11). This over-consistency may come about if the therapist is reluctant to address questions or engage in minimal social interactions. The perception also may result from empathic responses that are cognitively accurate but emotionally inadequate. It may be the consequence of a lack in the therapist's spontaneity and therapeutic presence. Consistent but shallow empathic understandings also may stimulate the client's perception of over-consistency. He may perceive the therapist as expressing a false self. (Brodley, 1999, p. 11).

Along with the non-directive attitude, it is important for the therapist to be emotionally present in the relationship (Brodley, 2002, p. 62). Brodley wrote, "A fundamental stance of the client-centered therapist is to act spontaneously (although it is a disciplined spontaneity) and authentically in our relationships with clients" (p. 68). Grant (1990) commented, "a client may request direction, advice, interpretations, or instructions, and the therapist may offer these" (p. 83). He also wrote, "non-directive client-centered therapy is a way of being, and not a method, because it allows the therapist to make novel, personal, unplanned responses" (Grant, 1990, p. 85). And Witty (2004) noted, "the fundamental aim of the client-centered therapist is to offer oneself in an entirely personal way, without professional façade" (p. 30). She added that client-centered therapists provide an environment for the emergence of a unique therapeutic relationship with each new client and with each client in successive sessions. ... (T)here is a *great deal of variation* in the ways client-centered practitioners interact with their clients—as much variation as there are persons (Witty, 2004, p. 30).

The kind of non-directive therapy described above is an extraordinarily difficult art to learn and practice. To allow one's whole self to participate in the relationship, with a non-directive intent, and, I would like to add, with an awareness of one's own issues, vulnerabilities, and biases, and also a willingness to acknowledge mistakes and errors, seems like a very challenging task for any beginning practitioner. It would be wonderful if in the United States

more training programs could be made available to learn this special skill, which is also an art.

Grant (this issue, p. 38) writes, "In my view, ethics are the heart of all therapeutic practices, and differences among practices should be articulated, defended, and challenged on moral grounds." For Grant (2004), the non-directive attitude epitomizes this ethical stance. For me, an equally important ethical value in the therapeutic relationship is the openness and honesty of communication, that is, the client-centered attitude of genuineness. In his review of my article, Grant does not comment on therapeutic genuineness, because he concentrates his focus on non-directivity. Rogers (1985) articulated the importance of this attitude when he was asked what the field of psychotherapy had learned over the past 100 years. He said "I don't know what the profession has learned, I really don't. I've learned to be more human in the relationship, but I am not sure that that's the direction the profession is going."

Sandor Ferenczi (1932/1985), at the dawn of psychoanalysis, epitomized the ethical quality of therapeutic openness, when he courageously experimented with different methods, including "mutual analysis," in order to help patients recover from trauma. Ferenczi, working by himself, and very much ahead of his time, wanted to maintain an atmosphere of maternal warmth in the therapeutic relationship through the expression of empathy, kindness, compassion, and love (Breger, 2000; Dupont, 1985). He criticized the detached and aloof manner of the mostly male analysts of his era, including Freud, for what he described as their "professional hypocrisy." He thought an analyst must be "indulgent," and should not frustrate the patient, an idea that contradicted Freud's principles of neutrality and abstinence (Breger, 2000, p. 348). To insure an empathic interaction with patients, Ferenczi recommended an analyst's own analysis, right down to "rock bottom" (Rachman, 1989, p. 183, pp. 193-194). Interestingly, mutual analysis reflected a true equality, where analyst and patient reversed roles in different sessions. For different reasons this procedure was not successful, and was abandoned by Ferenczi, but his motivation was to allow for greater honesty and openness in communication. His care and commitment to his patients, his willingness to be expressive, open,

real, and his desire to be self-aware, including of his own faults, continue to be important values of a therapeutic relationship.

One aspect of psychoanalysis that I have incorporated in my therapeutic work is an interest in the relationship between childhood experiences and current behavior and attitudes, which has been variously referred to in the psychoanalytic literature as transferences, organizing principles, or RIGs (representations of interactions that have been generalized). In the 1980s I wrote an article about this issue (Kahn, 1987) in response to John Shlien's (1987) important work at the time, "A Countertheory of Transference." In his paper, Shlien wrote that transference was a fiction. He demonstrated how transference can be used as a defense by analysts "to protect themselves from the consequences of their own behavior" (p. 15). For example, a patient's anger toward an analyst who is detached and neutral is not transference, but an appropriate response to an unfeeling analyst. In agreement with Shlien, I wrote that in an ideal therapeutic moment a therapist understands his or her client completely in a genuine, human interaction. This honest, empathic interaction of the here-and-now is wonderfully therapeutic. However, the transference relationship, which reflects the cause and effect determinism of the natural sciences, is also ever present for both the client as well as the therapist, and should not be ignored. For some clients, a reflective awareness of the past roots of their current issues may be therapeutically helpful. At times, and with some clients, I continue to be interested in understanding the relationship between the past and present, and I may ask a leading question or offer a tentative interpretation regarding these connections. Such an infrequent interpretation or question, when it occurs, is an example, I believe, of empathic understanding. I gave several examples of this phenomenon in my paper (Kahn, this issue).

I have also experienced on rare occasions clients talking about superficial topics in order to avoid getting to a deeper level or to a more difficult, conflictual topic (see Kahn, this issue). At these moments I may become a bit bored and I become aware that our communication lacks depth. (I have also experienced this same phenomenon in groups.) Since these are clients that I know well, I may ask a tentative leading question in order to change the direction of the session to what I believe the client is avoiding. Am I being an

expert, am I not respecting the client's self-determination, or is this an example of empathic understanding? Can a client-centered therapist just once in a while be an expert at something other than "not being an expert"? I do like to think that this kind of questioning is an example of empathic understanding, since recently a client, spontaneously thanked me for changing the direction of a session part way through our meeting. For this client, as a result of the change in content, our communication became more alive, real, and interactive. Such directive intentions by the therapist may be permissible in client-centered practice so long as they are infrequent and not systematic. For example, Brodley (1999) wrote,

Another normal contradiction, infrequent as it is in client-centered work, occurs when the therapist's remarks have a rare momentary directive intention. ... (T)he therapist wants to influence the client toward some particular idea, action or value. ... An occasional, albeit rare, moment of directive intention need not contradict the nondirective attitude as a constant in the relationship if the directivity is not systematic and not frequent (p. 11).

Brodley (1999) also quoted Raskin as saying,

the client-centered therapist may respond occasionally from her own frame of reference in various ways. Raskin's view is that doing so is an expression of a desirable therapist freedom—that it is valid in client-centered work as long as such communications are not systematic (p. 11).

Different ideas from Kohut's writings on self psychology have contributed to my understanding of clients, and I believe, as a result, enhanced my work as a therapist. For example, the idea that consistent empathic understanding, over time, will help strengthen the structure or cohesiveness of the self is often in the back of my mind. The idea that excessive sex, aggression, gambling, exercise, etc. may be

a way of stimulating a depleted, empty and depressed self has also enhanced my empathic understanding of particular clients who have had or continue to have behavioral excesses as their issue. Also my readings of the psychoanalytic literature (e.g. Hoffman, 1998; Bromberg, 1991), including lengthy case reports, has helped me be more aware, and perhaps more effective as a therapist. In one self psychology case report (Stolorow & Atwood, 1992, pp. 114-121) it was shown how a difficulty in the therapeutic relationship was about to cause an angry termination to therapy. This difficulty, however, was resolved as a result of the analyst's own therapy, which he was undergoing at the same time he was seeing his patient. He came to understand that his own vulnerability from a childhood trauma (death of his mother) was interfering with his empathic understanding of the needs of his patient.

Finally, findings from psychoanalytic infant research have illustrated the significance of the attuned relationship between mother and infant, the infant's need for "mirroring," as well as the need for the infant to disengage from the mother, and the importance of the mother's ability to respect this autonomy, will, and disengagement (her non-directive attitude) (Stern, 1985; Goleman, 1986; Beebe & Lachmann, 1992). As a matter of fact, this infant research seems to provide empirical support for the three client-centered attitudes, as well as non-directivity (the mother's ability to allow her infant to disengage and turn away from her). These findings also illustrate the remarkable overlap of core attitudes that are necessary in psychoanalysis, client-centered therapy, as well as in healthy parenting.

There are important differences between relational psychoanalysis and client-centered therapy. The relational analyst feels free to make therapist frame responses, and will not shy away from confrontations. However, Grant argues "that the practice of client-centered therapy consists fundamentally of the experience and expression of certain attitudes believed to be helpful and respectful of client self-determination (Brodley, 2002; Grant, 2004) and relational therapy does not" (this issue). I don't think this statement is true. When Bromberg (1991) writes, "the analyst's perception of his patient (his "knowing") is offered to the patient not as a corrective to the patient's faulty or distorted view but as a subjective impression to be

explored for its wrongness as well as for its compatibility with the patient's own experience (p. 435),” there does not seem to be a lack of respect for the patient’s self-determination. It seems to me, from his quote, that Bromberg’s perception is offered with non-directive intent. I imagine relational theory might give license to some less experienced analysts to respond with unempathic and hurtful confrontations, but judging from Bromberg’s quote there should be no interference with a patient’s self-determination in the relational approach.

I do agree with Grant, that there are differences between the psychoanalytic and the client-centered approaches, often based on the role of the “analyst” as an expert. Within psychoanalysis a pure and, what is considered, a superior form continues to exist. This approach involves lengthy training for the analysts, and multiple sessions per week and the use of the couch for patients. Aron (interviewed in Safran, 2009), a leading relational analyst, criticized the distinction that is made between this form of psychoanalysis and other kinds of psychotherapy. He said,

as long as we continue to distinguish between psychoanalysis and psychoanalytic therapy, then we have a hierarchy with a privileged elite, so that full-fledged psychoanalysts are somehow thought of as at a higher level than psychotherapists. And that, I think, plays right into a long historical tradition of psychoanalytic elitism, that puts down other kinds of therapists, and that has resulted in real problems (p. 100).

Analysts trained within this orthodox tradition usually prefer seeing patients multiple times per week (Safran, 2009; Stern, 2009; Carrere, 2010), and may urge patients to increase their frequency of visits, which is a form of directivity. On another matter, the holding of “master lecture classes,” which are offered at self psychology conferences, clearly diverges from the philosophy and ideals of the client-centered approach. And there is no experience in the psychoanalytic community like the one at the client-centered Warm

Springs Workshop, where new students have as much voice and power in the group as more seasoned professionals.

Grant believes that the client-centered approach, with its non-directive intent, and the three therapeutic attitudes, is morally superior to the psychoanalytic approaches I reviewed (this issue). In response, I have cited some of the complexities of the therapeutic interaction, and I would want to refrain from judging one approach as being morally superior to the other. Psychoanalysis, with the new and more humanistic developments in self psychology and the relational approach, and well-trained and well-analyzed practitioners, more often than not, I imagine, lives out the client-centered attitudes, including non-directivity, in their work with patients. My personal experience working with a relational analyst tends to confirm this notion.

Finally, regarding the ethics of therapy, I would like to end with an unedited quote by Sandor Ferenczi from his "Clinical Diary" (1933/1985). He wrote,

Should it even occur, as it does occasionally to me, that experiencing another's and my own suffering brings a tear to my eye (and one should not conceal this emotion from the patient), then the tears of doctor and of patient mingle in a sublimated communion, which perhaps finds its analogy only in the mother-child relationship. And this is the healing agent, which, like a kind of glue, binds together permanently the intellectually assembled fragments, surrounding even the personality thus repaired with a new aura of vitality and optimism (p. 65).

I would like to think that in this openness and honesty of communication, in a shared and caring therapeutic relationship, there is a strong similarity between Roger's and Brodley's client-centered therapy and Ferenczi's version of psychoanalysis.

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An Example of Client-Centered Therapy for Post-Traumatic Stress Disorder

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Abstract. *This paper presents a rationale for offering Client-Centered Therapy to a female medical clinic patient with symptoms of Posttraumatic Stress Disorder (PTSD), who was not seeking psychotherapy. Her therapy is on-going, and her progress during the first three years is presented. It is thought that many, if not most, people with PTSD do not seek treatment. It is hoped that this paper will provide a useful model for reaching out to them. Client-Centered Therapy can help clients feel safe to live authentically and/or feel safe enough to pursue other treatments designed specifically for PTSD.*

Introduction

Post-Traumatic Stress Disorder (PTSD) is the name given to symptoms that develop in response to an event involving perceived threat of death, serious injury, or other threats to one's physical integrity, or in response to witnessing an event involving the same threats to another person, or learning about those events happening to a close associate or family member (American Psychiatric Association, 1994). The diagnosis requires intense fear, helplessness or horror in response to the event. Symptoms include persistent re-experiencing, avoidance of things that are associated with the trauma, numbing of general responsiveness, and persistent symptoms of increased arousal, all resulting in impaired social, occupational or other significant

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functioning. One to 14% of the USA population experience PTSD at some time in their life. Combat veterans and victims of severe natural disasters have prevalence rates ranging from three to 58 percent. (American Psychiatric Association, *op. cit.*).

Military sexual trauma (MST) (including both sexual harassment and sexual assault that occurs in military settings, predominantly between military personnel from the same country) has been found to occur by 38% of men and 78% of women in the U.S. military (Street & Stafford, 2009). "Rates of attempted or completed sexual assault were 6% of women and 1% for men." Prevalence rates are difficult to determine. Victims are often reluctant to report sexual trauma due to perceived stigma and self-blame. This tendency is exacerbated in military culture that stresses toughness, a persona of invulnerability, and survival. Skinner, Kressin, Frayne *et al.* (2000) found 55% of female veterans reported a history of sexual harassment and 23% reported sexual assault while serving in the military (2000). In 2003, the Department of Veterans Affairs began universal screening of all patients for military sexual trauma. Positive responses were reported for 21.5% of women veterans and 1.1% of men (Kimerling, Gima, Smith, *et al.*, 2007.) Kimerling and her associates found a strong correlation between history of MST and PTSD, particularly for women. In a prospective study, Shipherd, Pineles, Gradus & Resnick (2009) found both male and female US Marine Corps recruits reporting sexual harassment experienced increases in PTSD symptoms six months later.

Treatment Options

Prolonged Exposure Therapy (sometimes referred to as "flooding" with noxious stimuli and "extinction" of maladaptive conditioned responses), Acceptance and Commitment Therapy, and various cognitive therapies have all demonstrated good rates of success in empirical studies of PTSD treatment. Unfortunately, these interventions involve remembering, discussing and to varying degrees, re-experiencing traumatic experiences in the process of recovery. As mentioned above, victims of sexual trauma are often reluctant to discuss their experience, and avoidance is a common symptom of

PTSD. As a result, many people with PTSD decline treatment. Furthermore, discontinuation of exposure therapy for PTSD (e.g., drop-out) before completion of the therapy can result in enhanced fear.

Deblinger et al. (2006) compare outcomes for children with PTSD due to repeated sexual and additional traumas treated with Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) or Child-Centered Therapy (CCT) for 12 weeks. Post-treatment outcomes and outcomes at 6 and 12-month follow-up were superior for TF-CBT in that children had significantly fewer PTSD symptoms and less shame than those treated with CCT. The children's caregivers also reported "less severe abuse-specific distress during the follow-up period than those who had been treated with CCT" (p. 1474).

Motivational Interviewing (Miller & Rollnick, 1998) is an offshoot of Client-Centered therapy that seeks to make clients more aware of ambivalence toward change and increase self-efficacy about entering treatment or making behavioral changes. In a sense, it is therapist-directed preparation for therapy using client-centered techniques¹. Motivational Interviewing may facilitate the successful referral of clients for prolonged exposure or cognitive PTSD therapies, or it may be used as an adjunct intervention to improve treatment retention and adherence (Slagle & Gray, 2007).

This paper describes the use of traditional Client-Centered Therapy to provide a safe relationship, allowing a survivor of military sexual trauma with symptoms of PTSD to experience herself in the present and openly share her thoughts and feelings. That experience can lead to increased self-confidence, self-care, improved communication with others and readiness to engage in treatments that confront PTSD more directly and perhaps more completely.

¹ This is an oversimplification. Motivational Interviewing can also be used as a comprehensive treatment approach and can provide the necessary assistance to allow clients to become genuine in their expression of thoughts and feelings. See Miller & Rollnick, *op cit.*

Outreach

Integrated Care refers to mental and physical health care services delivered in same setting by an *interdisciplinary* (as opposed to *multidisciplinary*) team of health care providers. Physicians, psychologists, social workers, occupational therapists, nurses and other providers work collaboratively to diagnose physical and psychological health problems, plan and provide treatment, and evaluate whether or not treatment is effective. This model of care is important because studies have shown that most people with mental health problems do not seek psychotherapy or psychiatry. Emergency rooms and primary medical care clinics are likely to be the first place that mental illness or stress is identified. Primary care physicians are usually not prepared to offer comprehensive mental health services, and their patients are typically reluctant to follow-through with referrals (U.S. Department of Health and Human Services, 1999). The American Psychological Association is advocating for structural changes in U.S. healthcare that would promote integrated care (American Psychological Association, 2008).

The Spinal Cord Injury Clinic of the VA Palo Alto Health Care System uses an integrated care model. When a client is seen by any health care professional in our clinic, no referral is needed to receive care from another discipline. Health care is delivered with a team approach. For example, if a nurse practitioner is concerned about a client showing symptoms of depression, she simply speaks to the psychologist in our common office suite, and the psychologist goes into the treatment room to see the client. The client does not need to go anywhere, or sign any forms. Communication between team members is on a personal level – notes are for documentation, not communication. Clients are informed that confidentiality is at the team level. There are no secrets between providers. That helps us to coordinate care for the client's benefit.

Integrated care was introduced to the United States Department of Veterans Affairs (V.A.) by its Geriatric Research Educational and Clinical Centers in the 1980s. It is currently conceived as the model of care for most VA health programs, though the degree of implementation varies greatly.

The Setting

The case example presented here comes from an integrated clinic specializing in life-long health care services for military and Public Health Corps Veterans with spinal cord injuries. All patients are seen by all disciplines at least once per year. Minimum services are guaranteed by national directive (VA directive 1176), enforced by Congress. A Congressionally chartered consumer service organization (The Paralyzed Veterans of America/PVA) has a National Service Representative on-site to monitor the quality and availability of care. The PVA's national office makes annual site visits, and reports their findings to VA Central Office in Washington, and to Congress. Local and national PVA officers are also clients in the clinic and our inpatient hospital service.

The New Client

In January 2006 we received the following referral information from the General Medicine Clinic: "51 year old female veteran seen in clinic for estab, moved from IL."

The veteran, Jane (pseudonym), was scheduled for an interdisciplinary new patient evaluation. One of our nurse practitioners saw her first and noted the following history:

"...paraplegia secondarily to a motor vehicle accident in January of 1994. She has recently moved from the Midwest and is establishing care through the spinal cord injury center here. She has no chief complaints today in regards to her spinal cord injury, other than chronic low back pain, ...and...neuropathic pain to bilateral lower extremities in right greater than left. ...Upon review of systems with patient, she has allergies related to thiopental [sodium pentothal]." Additional observations were noted regarding Jane's physical functioning: "Walks with a cane and an ankle-foot orthotic [to compensate for right foot drop.] Poor stamina due to weakness in both legs. Neurogenic bowel, treated with

diet. Urgent urination, no incontinence.” Jane’s medications were noted to include Prozac and One-a-day vitamin with ECGC metabolism accelerant.

The nurse practitioner also took a social history. She noted that Jane had moved with her elderly mother from the Midwest to a local mobile home park to save money. Jane’s mother reportedly wanted to be closer to her other daughters and grandchildren in California. The mother was in reasonably good health and drove a car. She was taking an antidepressant to cope with moving. Jane had a brother in another state.

When Jane was 14, her father died of a heart attack. Jane completed a year and a half of college. She had been separated from her husband since 1977. She served in the Army from 1977 – 1984. Prior to her spinal cord injury she drank 3-4 beers daily. At the time of intake at our clinic she drank only a small glass of wine with dinner.

In January 1994, Jane acquired a spinal cord injury and fractured hip in an automobile accident. She was a passenger when her step-father rear-ended a semi. She sustained a TBI (traumatic brain injury) at the same time, but did not lose consciousness

The nurse practitioner made the following observations:

- “Rapid speech and tangential thought. Patient appears hypomanic today. Patient declines [sic] previous history of diagnosis of mania or bipolar disorder. However, has currently been referred to mental health service for individual therapy.
- New heart murmur identified through general medicine service.
- Overweight with minimal activities as patient predominantly spends time watching TV. I recommend the patient have referral to SCI home care service through our recreation therapist to assist with adaptive PE program versus adaptive therapeutic swim. Patient wishes to think on this.”

The nurse practitioner shared her findings with me, and I reviewed Jane's responses to a screening questionnaire given annually to all clinic patients.

Questionnaire data:

- In the past year, the patient reports that her health was good.
- Her ability to do things she wants, e.g., recreation, ADLs was fair.
- Depression limited her weekly activity 0 hours per week.
- She has gotten out of the house daily.
- Her overall satisfaction with life was good.

With the above information, I began my initial interview with Jane. I learned additional history. She married 1975, but her husband is gay. She discovered his orientation when he was diagnosed with AIDS in 1977. She left him and joined the Army. Jane described herself as "reformed," having been "bad" 20 years ago. She did not elaborate. Jane said she usually got along with her three sisters and brother. She became angry when they criticized her past behavior or her relationship with their mother, whom they think she exploits.

Jane was unable to support herself financially. She had been an Army supply specialist from 1978 - 1984. She completed a medical transcription program after her injury in 1995, then worked until she was fired in 2003 for saying she had completed two reports that she had not. She said her temper was also a problem at work.

Since 2003 she has received disability insurance (SSD) payments for hearing problems that made her transcription work difficult. She worked occasional temporary jobs as a food demonstrator, and wanted to find such a job in California for 8 hours per week in order to buy a car.

Jane was unsure of how her SCI affected her sexual functioning, having had no partner since the mid 1990s.

I performed a mental status examination. That is standard practice for our clinic, and I thought it was particularly important due to Jane's history of TBI. She was alert and oriented to person, place, time and purpose of the examination. She was appropriately dressed

and groomed, and eye-contact was also appropriate. Jane's affect was cheerful. She was cooperative with the interview. Her memory / concentration appeared grossly intact. For example, she recalled my name, though only after being reminded and told I'd ask again. She readily recalled the past 3 presidents. She kept a calendar of her appointments, demonstrating ability to plan and organize. Her speech was pressured and her thought process was mildly tangential. She was easily re-directed to the topic at hand. Jane was responsive to questioning. She denied experiencing auditory or visual hallucinations, and none were evident. She said she slept from 1 to 5:30 A.M. nightly. Insight appeared within normal limits, but judgment was sub-optimal.

Jane reported her mood as euthymic and stable. She denied any history of mania, but said she has always been "hyper." She had taken valproic acid when she was first menopausal, but stopped when she started hormone replacement therapy. She had been taking Prozac for four years and said that helped with anger management. She had found individual psychotherapy very helpful in the Midwest. Jane had been referred to an anxiety group at our medical center, but she had tried group therapy once before and was not comfortable disclosing to peers.

Substance abusers often under-report use, so I routinely repeat the nurse practitioner's substance use assessment. Jane told me she smoked occasionally when anxious or in the company of others who did so. She was not interested in abstaining. She drank a glass of wine nightly with her mother. She drank 64 oz. of sugar-free cola per day, and ate "lots" of chocolate. She wanted to lose weight.

Jane's spinal cord injury is incomplete. She is able to walk, but tires quickly, and needs to be careful to avoid falling. I asked how she coped with this. She said that her primary coping strategy was to avoid thinking about her injury and other things that distress her. She also walked 10 minutes daily.

We ask all new clinic patients if they have experienced abuse or neglect related to their disability, and also if they have experienced military sexual trauma. Jane disclosed that she had been raped once during basic training and again at her "basic and permanent party." She had bad memories from time to time, occasional nightmares, and

found it difficult to let men get close. She said she had not been abused since military discharge.

I asked Jane if she was interested in psychotherapy. She was, and readily identified goals of experiencing stable mood and relationships with family, maintaining her current or lesser weight, and learning to function fully despite intermittent chronic pain.

The Diagnosis

In order to offer psychotherapy (or any other health care intervention), the VA requires assignment of a diagnosis. The Client-Centered literature has debated the wisdom of diagnosing clients, and I will digress briefly to review what I see as the advantages and disadvantages of this practice, beyond meeting an administrative requirement.

By their nature, diagnoses are reductionistic. No diagnostic label can convey the full experience of a client's experience, or even of their problems. Diagnoses can be a form stereotyping, prejudicing the therapist against recognizing the client's strengths and immediate experience. Diagnoses can elevate the therapist in his or her relationship to the client, labeling one as "sick" and the other "healthy." As a result of these problems, diagnoses can impede the therapist's capacity for empathy, and may blind the therapist to the client's true self.

On the other hand, diagnoses can provide advantages. They provide a framework for understanding the client's experience. If accepted as hypothetical rather than absolute, this framework can enhance empathy. They can give the client an identity, helping him or her realize that they are not alone in the symptoms they experience. Accurate diagnosis can assist in the coordination of care between disciplines and clinics. They can also result in financial benefit to the client. That is particularly true in the VA, where disabled veterans may be eligible for financial assistance depending on the diagnosis, severity and circumstances of a disability.

Given the history I knew at the time, and Jane's presentation during the initial examination, I believed she was experiencing Posttraumatic Stress Disorder secondary to military sexual trauma. It

seemed difficult for her to discuss her trauma, and whatever behavior she had alluded to when saying she had been “bad” in the past. For those reasons, I thought she would be best served by a female therapist.

As mentioned above, Jane had already been referred to the Mental Health Clinic (MHC) by General Medicine. I encouraged her to keep that appointment and use it as an opportunity to clarify her goals and see what services they could offer. She could then decide if individual treatment at the Spinal Cord Injury Clinic with my female trainee made sense in addition to what MHC could offer.

A Second Opinion

The intake worker at MHC wrote the following assessment after her interview with Jane:

“Patient exhibits mild to moderate psychomotor agitation and speech is slightly pressured. She is looking for individual treatment (someone to vent to). She reports some family communication problems and is quite frustrated by this. She reports limited social support. She reports some explosive anger, usually verbal outbursts and one incident of throwing a glass at her sister last summer before they moved to California. She reports no other physical outbursts and denies any physical violence towards anyone (hitting, kicking). She reports sleeping only 5 hours each night (1 a.m. to 6 a.m.) but states that she sometimes takes naps during the day. She reports some irritability and boredom. She states that she is not able to get out of the house very often. She denies any suicidal or homicidal ideation. She was raped twice in the military. She reports some avoidance (won't go out alone after dark, has some difficulty talking about the rapes), some exaggerated startle response (i.e. if someone walks up behind her and taps her on the shoulder), a history of nightmares

(last one was a month ago). She abruptly changed the subject after questioning her about her symptoms.”

Regarding her treatment history, “She denies any history of hospitalization, suicide attempts, and physical violence. She reports the first time she sought psychiatric help was in the 1970's for depression and marital problems, but it was a group session and she did not feel comfortable speaking in front of the group. She only went once or twice. Three or four years ago she sought treatment again in order to "talk about family matters and have a sounding board". She says that her anger was better because she had someone to talk to.”

The intake worker obtained further information regarding Jane's history of substance abuse:

“She reports that 20 years ago she used crack cocaine and marijuana because she was in a relationship with someone who used, but she quit 20 years ago and has not had any trouble staying clean since then. She denies any current drug use.”

The intake worker had the following DSM-IV diagnostic impressions:

Axis I: hypomania vs. anger/anxiety due to PTSD

Axis II: deferred

Axis III: past MVA, back pain, menopausal difficulties

Axis IV: limited social support, family difficulties

Axis V: GAF: 50

They agreed on a prescription for Paxil 20 mg daily and monthly case management. Jane declined individual therapy with my trainee.

One month later at the Mental Health Clinic:

“...client reports that things have been going better since her dose of antidepressant was increased. She has been doing a lot of gardening which is physically exhausting on the one hand but very satisfying. She reports that one of her major stressors had been having contact with her two sisters who live in the area. While they are both going to be traveling coming up she has generally been able to get along better with them and less reactive. She reports that they have a sleep over planned... [and they enjoyed a live musical together]. Client is feeling good about her mother as well. There seems to generally be less stress. Client has a trip planned to go back to a friend's daughter's wedding in the Midwest as well. Client reports that sleep, concentration and mood are improved.”

The diagnosis was changed to “Mood disorder not otherwise specified.” The treatment plan was to continue case management every two months, see a psychiatrist every three months, continue taking Paxil, and use music and exercise to cope when her mood is depressed.

More Outreach

Jane returned to our clinic in March 2007 for her annual evaluation. She was seen by my student, Laura, who decided to ask for a more complete history. Laura wrote:

“Patient reports that she has been feeling sad since the death of her uncle this week. She reports that her uncle is the brother who looked most like her deceased father and as such his death has brought up sad memories. Patient reports that she continues to experience conflict with her siblings who she feels judge her and don't understand her. She reports that for many years she has been trying to ignore the bad things that have

happened to her, but she has noticed that over the last couple of years she finds this harder to do and as such she feels sad more often.”

Developmental history: Jane is the youngest of five siblings. “She reports that she sometimes got along well with [one of them] in her childhood, but mostly she felt as though she was different to her siblings and they were never particularly close. She reports that her siblings were all "A" students and she feels as though she was always being compared negatively to them.”

“Patient also reports that she had a difficult relationship with her father with whom she was in constant conflict. She now attributes this to them both being determined, and similar personalities. Patient reports that on Homecoming night when she was in 9th grade, her father died unexpectedly from an aortic stenosis. Earlier that day, patient reports that they had fought and she had called him names and stormed out of the home. She reports that this left her feeling very guilty and also angry at her father for leaving her. She reports that she still feels some of this guilt and anger.”

“...[Jane] reports that two years following her father's death, her mother remarried to a man who she liked. However, she reports that she did not get along with her new step-brother ...who is her age. She reports that her step-father often negatively compared her to [him] and, although she liked him, this caused conflict. Patient reports that her step-father died three years ago and that she still misses him. During high school, patient reports that in addition to not being as good academically as her siblings, she got into a lot of trouble, including smoking pot and mescaline. She denies any legal trouble.”

“Following high school, patient reports that she married her high school boyfriend. She reports that her family did not approve of this because he was African American and so they were not very supportive when he told her two years later that he was gay. Patient left him at this point and joined the military. ...She reports being raped twice. The first instance occurred during basic training. Patient reports remembering little about this instance but knows that there were two men. She reports that it is possible that they had been drinking which was against the rules of basic training and as such she did not report the incident. She was later raped following basic training by four men. She reports that someone with whom she served lured her into a building where she was then assaulted by him and three other men that she did not know. She reports that one of them choked her and threatened to kill her if she ever reported this and so she never told anyone.”

“After leaving the military in 1984, patient reports working for the post office. She reports that she dated several men casually and would not allow anyone to touch her sexually or to get close to her emotionally. However, she reports that she then met a man with whom she fell in love before realizing that he was married. They were involved for two years, during which time he physically abused her. When she lost her job, she reports that she moved down to San Diego to live with her sister and left this man. At that time, she became friendly with a girl who introduced her to crack cocaine. Patient reports that she has no clear recollections of what happened to her during the two years that she was using crack cocaine, but has vague memories of waking up in terrible places and hating herself for doing this. After about two years, patient reports that she decided one day to get away from this

lifestyle and stopped seeing her friend and just stopped using crack.”

“Behavioral Observations: Patient presented casually but appropriately dressed and appears to be her stated age. Her speech... rate is fast. Despite the painful nature of the subject matter, her affect was inappropriately cheerful throughout. Her thought process was somewhat tangential, but she was easily redirected and it seemed more to needing an outlet....

“Impressions: ...[Jane] has experienced an inordinate amount of trauma in her life that she has been trying to deny. She is likely to have experienced complicated grief symptoms when her father died, and this combined with her sense of being unable to live up to her siblings may have contributed to her acting out in school. The consequent criticism that this produced seems likely to have compounded the sense of worthlessness she reports feeling from a young age. This is likely to have led to her exercising poor judgment and placing her at risk for the later traumas that she has endured. Her denial of the pain she has experienced, and the later use of drugs are suggestive of an avoidant coping style. Having someone with whom to talk, without judgment or criticism is likely to be extremely beneficial to beginning to counter her beliefs of being worthless and unlovable.”

Laura considered several diagnostic options, including Major Depressive Disorder, Cyclothymic Disorder, and subthreshold (because not all DSM IV criteria were observed) Posttraumatic Stress Disorder. Jane felt good about their first meeting, and agreed to begin weekly psychotherapy.

Then-current social stressors included unemployment, poverty, social isolation and conflict with siblings. Due to the history of successive traumas each associated with increasing social avoidance

(including avoiding intimate relationships with men), avoidance of negative emotions by tangential responses, depressed mood, chronic anxiety, and hyperarousal, I assigned the diagnosis of Posttraumatic Stress Disorder.

Jane had declined referral to group therapies for PTSD at the Mental Health Clinic. She did not trust peers with her history and experience. She generally avoided discussion of her traumas, and we did not think it wise to push her toward doing that before she was ready. Client-centered therapy offered us the opportunity to show Jane that we could trust her to decide what was best to talk about, and show her that we could value what and how she chose to communicate.

Client-Centered Therapy Begins

In her first session with Laura, Jane discussed problems with social isolation and conflicts with her family.

“Patient reports that the only people that she currently spends any time with are her family. She attributes this to having difficulties knowing how to build relationships now because she has learned that she is not good at knowing who she should trust. She acknowledges that this is not good for her since her siblings and mother are major sources of ongoing stress for her. She reports feeling as though they are constantly nagging and judging her.”

... “Her particular difficulty relates to her sense that they consistently bring up her past actions such as her drug use and use this to put her down. Patient reports that she often becomes defensive when this happens which escalates the conflicts and that she knows that she needs to simply disengage. Patient reports that she thinks that she has heard so much criticism of herself as a person over the years that she has just learned to believe that it is true.”

Jane also spent much of the session berating herself for not going to the gym to exercise three times weekly as planned. She was very concerned about her weight, and felt she had failed. Laura proposed in supervision to help Jane break her weight reduction plan into small steps that she was likely to complete successfully (behavior therapy). I suggested that she share this idea with Jane and let her choose. Jane decided to accept Laura's offer to coach her in weight reduction. Notably, Jane's plan also involved increased socialization by going to the gym at her trailer park.

The next three sessions were characterized by rapid behavioral gains. Jane heard Laura's disclosure that Laura would prefer her to go slowly and she went to the gym once the first week, then three times the following two weeks. She felt better about her interactions with her sisters because she changed the subject when they brought up her past, and she started asking about their activities and feelings.

Progress?

In March 2007, Jane's MHC Case manager administered the VA's annual screening questionnaire for PTSD.

PTSD Screen:

Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you:

- Have had any nightmares about it or thought about it when you did not want to? Yes
- Tried hard not to think about it or went out of your way to avoid situations that remind you of it? Yes
- Were constantly on guard, watchful, or easily startled? Yes
- Felt numb or detached from others, activities, or your surroundings? No
- A four-question Primary Care PTSD screen was positive.

For the first time since beginning care at our medical center, Jane endorsed sufficient criteria for the standard DSM-IV diagnosis of PTSD. Does that mean Jane was getting worse? I think not. Instead, I think that due to her work with Laura, Jane was more comfortable thinking about and disclosing her symptoms.

In the next psychotherapy session Jane reported she'd gone to the gym every day. Besides benefiting from exercise, she enjoyed socializing with women there. However, she was hurt and puzzled that another woman abruptly rejected her suggestion that they meet socially outside the gym. Jane concluded that people need to be cautious. She said she continues to experience some ambivalence about discussing her trauma history. She acknowledges that the constant presence of these memories allows them to have control over her but she fears losing control if she were to begin talking about them and processing her emotional response to them. Patient reports the belief that it is better to just let them all out at once, but fears that this will be overwhelming for her.

The next session Jane introduced a plethora of mundane topics. She said her relatives were out of town, so nothing was bothering her except a toothache. At the end, she blamed Laura for an unproductive session due to making uninteresting responses. Laura empathized, and then replied that she thought her responses reflected what Jane had expressed. Laura and I wondered if this was a client-centered comment (genuineness expressed to disclose the client's impact on the therapist), or a comment made by Laura to defend herself. I found Laura to be remarkably non-defensive, and Jane's report in the next session indicated that she had not felt blamed or attacked.

In the next session, Jane announced that she had quit smoking, and lost her cell phone. Her thoughts about people who might take advantage of this led to self-disclosure about having stolen to buy crack cocaine. At first she blamed the influence of her friend, but then she stated she was responsible for her own choices.

The following session was characterized by changing the topic so rapidly that I had great difficulty understanding the content. Her speech was rapid with loose associations, though the content was not delusional. Jane mentioned nightmares about being unable to escape

from someone trying to harm her, looking for an affordable apartment on Craig's List, and being shocked by the personal ads she saw. She said she did not understand why she felt so vulnerable at this time.

Like many clients, significant progress by Jane is often followed by regression to more familiar behavior in the next session or longer. Psychodynamic therapists think of this as a way of clients reassuring themselves that they can still deploy ego defenses against painful experience if they choose to do so. I find that concept useful in the client-centered relationship as well, to prevent *myself* from being discouraged by the client's present experience. In client-centered therapy it is not necessary to share this interpretation with the client.

Next session Jane said she was lonely and she feared it would be difficult to trust a new therapist after Laura left.

Jane said she believes that her experiences of being raped contribute to her sense of distrust for people. She now keeps her distance from men and will not consider engaging in an intimate relationship. She expressed the belief that she deserved to be raped in some way and that the second rape served to compound this belief. She acknowledged that she perhaps it is not really her fault, but expressed the belief that it is normal for her to blame herself because she put herself in the position where she was at risk and perhaps did not fight hard enough on either occasion. She also expressed that since she did not report either incident this contributes to her responsibility. She repeated this content the following week.

The last week of June was another of rapid, pressured, loosely associated content. In the last 5 minutes, Jane acknowledged her anxiety about changing therapists when Laura's training rotation ended in August 2007, and stated she was confident she would open up again despite the difficulty because she knew she had made much progress with Laura.

The following week, she said her progress came from being able to discuss difficult topics without being judged, and she knew she needed to continue this though it was easier to suppress.

Next session she was able to talk about her sadness about losing Laura, and her life-long loneliness.

Reflecting on her sense of progress, she said that by occasionally referring to her trauma history, she had begun the process

of "letting the skeletons out of the closet" and she believed that with time, she will reach a place where she is more ready to fully address the issues around her experiences.

A Change of Therapists

August 23, 2007 was a transitional session with Laura and the new therapist, Erin.

Jane stated that she enjoyed having a non-judgmental listener, and (referring to sessions when she disclosed nothing personal) was sometimes uncomfortable when the feedback Laura gave her was not as expected.

She'd had to euthanize her cat, but felt okay because it was the "right thing to do." She'd started smoking again, and declined a referral for smoking cessation.

Jane's presentation was similar to our first meeting. She was loquacious and tangential, describing herself as "the baby" of her family as the youngest of five children. She said that she "did some bad things" in the past, and that her older siblings often remind her of her mistakes which bothers her quite a lot. She also reported that according to her mother she was a bright, precocious young child, but that she went on to not do very well in school and was diagnosed with learning disabilities.

Two sessions continued the theme of "safe" material that was difficult to follow. Jane commented in passing that although she talked mostly about other people in her life, she still found therapy helpful because this content had been on her mind. In supervision, I focused on helping Erin be patient and trust that Jane would know when she was ready to delve into more of her immediate experience and trauma history.

In mid-September 2007, Jane brought up her rapes halfway thru the session. She recounted the events, adding that another factor in not filing complaints was that she expected to be looked down upon and blamed. In the years since her traumas she had done her best to keep the memories "locked up," but that they came back to her at certain times, like when she heard a particular song or saw a man that reminded her of one of her perpetrators. She also mentioned that in

her experience most men have a tendency to be "rough during sex," so she doesn't miss" being involved with a man.

Subsequent sessions were characterized by appearing happier, avoidant and difficult to follow. She occasionally touched on traumatic experiences in a superficial manner. She also started talking about important practical matters (e.g. housing and savings) in a trivial way. Already bankrupt, Jane had been the victim of identity theft. She also spoke critically of her best friend, whom she saw as irresponsible and self-absorbed. The Mental Health Clinic started seeing her every three months instead of monthly, and Jane missed several therapy sessions due to transportation problems.

In November, Jane spoke to her banker and worked out a way to establish credit. She bought a car and began to lose weight. She described psychotherapy as cleansing. However, by late December she injured herself after drinking too much at a party, and was over-drawn from not keeping track of how much she spent on Christmas gifts. She was up-beat and expressed confidence that her problems would work themselves out.

In January, Jane shared the story of her father's death. She opened her wallet and shared pictures of him, her mother and her husband. Similar to when she told her other trauma stories, her affect remained cheerful. She said she occasionally felt "down" due to the weather. In February, 2008, Jane talked about several times that her mother's dog had bitten her. She blamed herself for being intrusive. To her credit, Erin resisted the temptation to interpret this as Jane allowing herself to be abused. She trusted that Jane would eventually take care of herself if she were trusted to do so.

Next session, Jane talked about a visit by one of her sisters. The sister had told her that she needs to treat their mother better, make more of an effort to think of others versus only herself, do more to keep up the house, and be more "social" instead of watching so much TV. Jane admitted she could do more around the house. She then explained to Erin (her therapist) that she gets frustrated with her mother because she does not hear very well and often misunderstands what she says, and her sisters literally do not understand her. She reported that her friends do not have a problem understanding her in conversation, even when she "goes off on tangents". She said that she

can say the most straightforward thing and her family still will say that they are confused and question her. This frustrates her, so she watches T.V. to avoid an argument. Weeks later, she said she was grateful to be able to express herself freely in therapy because she feared being judged if she did so with her family.

A Breakthrough

In March (27 months after intake), while talking to a friend, Jane realized that her three best friends always say the same old thing, and that she is getting tired of hearing it. She also said that they primarily talk about themselves, and only occasionally ask about how she is doing. She reported that she had an "aha moment," in which she realized that the way she was feeling during their conversation -- ignored, bored, and annoyed, is how her family must often feel in speaking with her. She said that she actually said the word "aha" aloud upon making this realization. Jane reported with some incredulity that she has never thought about her relationship with her family from this perspective before. She expressed hope that her relationship with them will improve as she begins to change her approach to interacting with them.

The next week she was particularly tangential in session. Later, she said she realized she was being superficial, and blamed Erin.

Jane's world continued to be fragile and uncertain. On March 31, 2008 a spot on her lung was reported after x-ray for her SCI annual evaluation. She quit smoking. She denied being anxious, but was more difficult to understand. Her same-aged cousin killed himself. Jane quit exercising and Weight-Watchers. In April she began to prepare for a change of therapists when Erin's training ended in August.

In the end of June, Jane borrowed \$500 from her mother for car repairs, and did not have \$700 she needed for dental work. She told Erin she was "fine."

In the end of July, Jane had begun to save money. She held a birthday party for her mother and got along well with her sisters.

August 1, 2008 was her last session with Erin. Jane's mother had accidentally killed the dog. Jane said she looked forward to playing with her sister's dogs when she and her mother traveled to see her. She

acknowledged making progress in therapy, and agreed to see a new therapist after visiting her sister.

The Third Therapist

Jane met her new therapist, Olga, late in August 2008. She discussed her new role as caregiver due to her mother's new health problems. She seemed to be effective in this role. She seemed empathic toward her mother, and insightful regarding the impact of her empathy. However, Jane became increasingly tangential in subsequent sessions. She was sad that her mother was preoccupied with death, and also worried about being homeless when her mother died, yet her affect remained cheerful.

Putting the Mask Aside (For A Bit)

In October 2008, Jane got a puppy to cheer her mother up. This became an unexpected source of stress, as Jane had taken a second part-time job and had not anticipated how much work it is to care for a puppy. Additionally, her mother was not pleased at having a new pet. For the first time, Jane's affect was congruent with her thought content. In November her MHC visits were decreased to every 4 months.

In December, Jane planned to drive somewhere new for recreation. She explained that this was a big step because she had a serious fear of being lost. She decreased her work hours because she did not think it safe to leave her mother alone. She requested help from our SW to find subsidized housing for after her mother died, having refused this three years earlier. She also re-started gapapentin for pain, having stopped it two years earlier.

Instrumental Support

On March 25, 2009, at my suggestion, Olga told Jane about the possibility of filing a claim for Service-connected compensation for the consequences of military sexual trauma.

Jane reported that she had lost both her jobs due to the economy. She felt emotionally prepared to discuss the events surrounding her military trauma. She noted that she had not thought of these events for a long time and was concerned that "jumping in cold turkey" would cause her marked distress. Olga offered to discuss her traumatic experiences in therapy prior to disclosing this information to the PVA benefits representative.

Was this a Client-Centered therapy intervention? Jane was concerned about her finances, and had begun to seek additional resources. She might have found out about her eligibility to make a service-connected disability claim from her Social Worker. However, the process of making a claim involves providing detailed information about the relevant traumas in writing, defending the claim in correspondence with the VA Regional Benefits Office, and discussing the trauma with a disability evaluator. Providing this information to Jane, along with empathy for her choices and the consequences, in the context of her search for resources, seemed both Client-Centered and caring. While education and referral go beyond Rogers' core therapy conditions, I think these interventions are consistent with the model as long as they follow the client's lead. Olga did not recommend that Jane apply for benefits. She only informed Jane of the option and what it would require, and made herself available to support Jane whether she chose to pursue this or not.

Another Transition

Over the next two weeks, Jane looked worse, but was unusually coherent. She said that she no longer thinks about these events daily but can feel their effect on her current functioning. Jane stated that she "is a broken person," whose personhood "was violently taken" from her. She shared that the rapes made her feel "guilty, dirty, ashamed" and that she felt "empty, as if they left me with a shell of myself, nothing inside." She spoke about not sharing with anyone because she was threatened by her assailants (told her they would "simply kill you if you talk, throw you out the window in the barracks"). Patient described the emotional and physical damage that resulted from the assaults. She was forced to return to military service with the men who

raped her (both during the basic training and later at her post abroad) as she did not feel safe to report the rapes to her commanding officers. She described the importance of small tangible things from home that gave her comfort and were the only source of emotional safety while she was in the military. She felt "damaged, unable to trust any man for the rest of my life," unable to sustain a meaningful interpersonal relationship with a man, always suspecting that she could be raped again.

She described episodes of intense fear followed by detachment/depersonalization, "acting like robot." Jane stated that for many years following the trauma, she experienced intrusive and distressing flashbacks and dreams of the rapes. She has withdrawn from social contact and only felt safe staying at home. She was not able to maintain a job that required her to be outside of her house. Jane reported that she has been avoiding anything that reminded her of these traumatic events and that it took her years to be able to compartmentalize the memories related to her sexual abuse. She also shared that she has not had a satisfactory sexual relationship since being raped as she is unable to trust others or allow herself to enjoy intimacy, which she associated with feeling "dirty and guilty." At the end of the session, Jane summed up that the rapes robbed her of "full life and good future" but that she was able to survive and has slowly put the pieces of life back together. Jane noted that she "was a broken puzzle" when she was discharged from the military. She is now able to recognize the sort of tremendous effort it took to "get all the pieces together." She ended by saying that she was hoping she "was doing well enough."

After two more sessions, Jane met with an advocate, and brought a benefits application to fill out with Olga. She also made plans to deal pro-actively with problems she anticipated in dealing with A, who planned to help her care for their mother.

In her most recent session (June 2009), Jane discussed concerns related to a request from the VA for more information concerning her benefits claim. She has no documentation to support her claim, and has forgotten many details. While anxious, she did not report an increase in other symptoms, and has begun to discuss termination with her third therapist.

Regarding her rapes, on 6/17/09 Nancy concluded that, although it is not likely that she "would ever be able to get over it," she is content with being able to talk about it now "without falling apart."

Future Plans

Making an official report of her rapes is an important step toward Jane revealing her true self to others. Her long-standing fear that she will not be believed may be realized due to her lack of documentation and inability to recall the names of her assailants. Jane will continue to discuss this with her therapist, and will integrate that experience with her efforts to be more authentic with her siblings and friends. She has declined a referral for peer support, but may reconsider that in the future. She will soon need to talk about plans to transition to another therapist, and may eventually be ready to try therapies developed specifically for PTSD. As she faces the inevitable prospect of living without her elderly mother and needing to support herself financially, Jane has begun to discuss housing options with her social worker. An empathic ear may help her overcome her resistance to signing onto the long waitlists for subsidized housing, and establish financial independence from her family of origin.

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The subject of this paper has reviewed the paper and given permission for its publication.

Jon Rose, Ph.D.

Uses and Limitations of the Non-Directivity Paradigm for Therapy with Families in Crisis

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Abstract. *The non-directivity paradigm is briefly examined in light of family systems theory. Purist and non-purist positions on non-directivity parallel the family systems perspective and the feminist critique of family systems. The complementarity of these polarities are asserted to be essential to counseling.*

Rogers (1949) questions whether a counselor should be willing to let a client choose goals that are antisocial, immoral, or self-destructive; in his answer he said that that “only as the therapist is completely willing that *any* outcome, any direction, may be chosen—only then does he realize the vital strength of the capacity and potentiality of the individual for constructive action” (p. 94). This statement articulates what might be termed the purist or idealist pole of Rogers’ viewpoints on the scope of the nondirective paradigm, a scope which is here seen to be unlimited. Rogers defended the purist viewpoint by contrasting it with “confused eclecticism,” (p. 85) in which a helping professional limits the scope of the non-directive paradigm and says to him or herself, “I will hypothesize that the individual has a limited capacity to understand himself to some degree in certain types of situations” (p. 84). Rogers makes the undeniable point that to be certain and unwavering on this point will yield theoretical certainty and provide clear guidance for the counselor in how to act, and reiterates that the more the counselor “relies on the strength and potentiality of the client, the more deeply does he discover that strength” (p. 94).

But is this a realistic position? Rogers himself issued at times contradictory statements on whether the nondirective approach can be applied in all cases. Earlier, he appeared to somewhat circumscribe the nondirective approach, saying that while it “applies to the overwhelming majority of clients who have the capacity to achieve

reasonably adequate solutions for their problems” it “cannot be the only method for dealing with that small group—the psychotic, the defective, and perhaps some others—who have not the capacity to solve their own difficulties” (Rogers, 1942, p. 87). While his statement is framed mainly in terms of client population, it also provides a larger framework to understand the issue—that the broader issue is the ability to solve difficulties in an autonomous fashion. Diminished ability unites the different populations of the psychotic and the mentally handicapped, and renders them potentially unsuitable for client-centered therapy, at least without adjunct treatment (see, however, Prouty, 1994, for one recent client-centered approach to these populations).

It is this non-purist pole that expresses a consensus opinion held over the years by many counselors, which stated that while Rogers’ approach works well for mundane issues and personal growth with highly motivated, highly functioning clients, it wasn’t appropriate for those “some others” with diminished capacities—such as clients in crisis situations who require a counselor be more active and directive (Presbury, McKee, & Echterling, 2007). It is likely that this “middle of the road” position characterizes the majority of practicing clinicians. Indeed, at the recent ADPCA conference, skepticism was expressed by some as to how practical it was to be radically noninterventionist and person-centered. As illustrated by poignant anecdotes, clinicians face at times life-threatening challenges in applying a purist position. In one case, a clinician did not intervene to prevent a client in a group home from harming another client in that home. The clinician was devastated, wondering if she should have set aside her noninterventionist stance in favor of a more active, directive approach. Trusting fully to the individual’s capacity to take constructive action is not for the fainthearted, especially when that individual is in crisis.

The situation is as challenging, if not more so, when the treatment unit is the family. Embedded in the history and development of family therapy has been the revision of general systems/cybernetics theory (Bateson, 1972; Bertalanffy, 1968) through feminist critiques about the lack of accountability in these theories (Goldner, 1985; 1993; Hare-Mustin, 1978; 1986). These critiques provide a map for the dilemmas that can arise when attempting to implement a nondirective

(i.e., systems) paradigm with a family. Issues of power and hierarchy suffuse normal family functioning, and are certainly at least as prevalent, if not more so, when a family begins to experience dysfunction. From a systemic, nondirective, and noninterventionist perspective, the viewpoints and actions of all the family members recursively interact to produce their family system. However, depending on age and gender, a viewpoint may carry more or less weight. With children involved, and with issues of power, control and gender present, then non-directivity in family therapy, like a systems orientation, is open to critique.

Rather than assuming that a family in crisis is fully capable or fully incapable of finding adequate, ethically balanced solutions to its problems, a further exploration of the nondirective paradigm is needed. Rogers (1949) himself makes the evocative statements that the basic philosophical attitude of the counselor “may be adopted tentatively and partially, and put to the test” and that “the possibility of self-understanding is still, for this client, a completely unproved hypothesis” (p. 84). These statements resonate with the various theorists in family therapy whose work compliments person-centered approaches, such as Narrative therapy (White & Epston, 1990) and the Milan school (Boscolo, Cechhin, Hoffman, & Penn, 1987) and their interest in circular questioning (Penn, 1982), which can serve to make explicit the interactions and the power hierarchies in a family. These approaches have generated some of the more sophisticated explications of the uses and limitations of curiosity and nonintervention, and would provide a good “marriage” with Rogers’ more tentative formulation.

In coupling family therapy and the person-centered approach, which some theorists see as a harmonious relationship (e.g., Gaylin, 2001), perhaps it would be useful to resurrect the at-times discredited term of complementarity. As Goldner (1985) observes, this term, as applied to couples, has paralleled the sociological notion of sex roles. While it perhaps mistakenly gives socially constructed norms an aura of biological and psychological determinism, yet if one recognizes how it is structured by social context, complementarity itself can still be of some use. That is, the complementarity between nondirective and directive approaches is a polarity inscribed into the counseling

relationship itself. It may be that this is one of those never-ending arguments between vitally linked concepts (or people) that refuse to die because if the argument were finally answered, the relationship would end. Counseling is constructed from these vitally linked arguments: research versus practice, idealism versus realism (at the conference, those who were seen as ideological purists were described by one clinician as “idealistic academics”), change versus acceptance, “circular thinking” versus “linear thinking,” and so on.

There is clinical utility in intersecting the nondirective paradigm with the aforementioned debate in family therapy, along with linked arguments about authority (Nichols, 1993), constructivism (Minuchin, 1991), and deconstruction (White, 1993) and the therapeutic uses and misuses of philosophers such as Foucault (Fish, 1993; Redekop, 1995) who analyze power and power relationships. Accounting for power differentials while maintaining a systems orientation is a key attitude for the family therapist, one that permits both the generation of hypotheses about the family as well as accountability for choices made or not made to implement these hypotheses. Counselors continually generate hypotheses about how far they might go to will *any* outcome, *any* direction. Sixty years after Rogers' (1949) statement, how counselors answer the question of non-directivity with individual and family clients remains at the heart of the therapeutic enterprise.

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Person-Centered Counseling in the Schools

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Meeting the individual needs of students is a primary goal for the school counselor. Often this goal is a moving target dependent upon the developmental needs of the student and the evolving needs of the community. Within one community, student needs may range from assistance in the college application process to an exclusive university to helping a student cope with the daily challenges of homelessness and poverty. Fundamental to providing counseling across such a large spectrum of needs are the basic facilitative skills of genuineness, acceptance, trust and empathic understanding (Rogers, 1994). As school counselors, we are trained in these skills; however, the experience of the “real” world provides unforeseen challenges.

The American School Counseling Association recommends a ratio of one counselor to 250 school students. In reality, the national 2006-2007 average of school counselor to student for the 2006-2007 school year was 475 (ASCA, 2008). Large urban school districts often have more than 500 students assigned to one counselor (Graham, 2009). With these numbers in mind, how does a counselor establish a climate conducive to self-expression and genuine, empathic understanding? According to Rogers in the *Freedom to Learn*, counselors support the “facilitation of change and learning” through the development of a relationship. The “development of relationship” aspect of a school counselors’ role is extensive. Counselors build relationships with students, teachers, parents, administrators and community members. So exactly how do we go about developing these relationships in the school setting?

Student-Counselor Relationship

Essential to the facilitation of change is the development of rapport with students (Axline, 1947). The person-centered counseling approach provides a fundamental philosophical orientation and way of

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being in which to develop these relationships. Specifically, Roger's three core conditions of genuineness (congruence), unconditional positive regard and empathetic understanding provide the foundation for the counseling relationship.

Working with children and adolescents can be humbling. Humbling because, although children and adolescents are in the developmental process of learning how to be congruent-- they tend to be very "real." And with their realness, they set a standard for the counselor. A person-centered school counselor strives to be genuine, even transparent. As Rogers noted, "The term "transparent" catches the flavor of this condition: the therapist makes himself or herself transparent to the client; the client can see right through what the therapist *is* in the relationship; the client experiences no holding back on the part of the therapist". In a "real" way, present yourself to *your* student as a person – it goes a long way with an individual in the throes of adolescence and self-identity exploration.

As a school counselor, there may be 500 or more students on your caseload. Will you like them all? Probably not. However, as a person-centered counselor, your responsibility is to provide each client or student with unconditional positive regard. Everyone (no qualifiers provided) deserves someone, some place, somewhere, somehow, who accepts them as the vulnerable human being they are. How do we do this with so many students and their very complex needs? I believe it is all about context. Place your student in the context of his or her life – and it is so easy to see them as an individual, identify their innate goodness, then accept them and regard them with the dignity and basic human respect that all deserve. Schools are systems – systems are susceptible to overlooking the individual.

As the school counselor, be the "protector" of the "individual." Listen with empathic understanding. Yes, easier said than done, and some days our heads can spin with the varied and complex concerns of our students. In any given day, student issues range from "someone wouldn't look at me at the locker" to "my mother is going to prison." As Rogers stated, "we think we listen but very rarely do we listen with real understanding, true empathy." Are you really listening?

Students are seeking an adult to connect with – or they wouldn't be waiting outside your office. So, as the line of students

outside the office door seems to grow exponentially, remind yourself to meet each student with eye contact, empathy understanding and genuine respect. Having worked with adolescents for many years, one of the top complaints I hear is that adults do not listen to them. “Kids know” – if you aren’t open, accepting and empathic, they may or may not chose call you out on it, but they *do* know.

Teacher-Counselor Collaboration

School Counselors address the academic, career, social and emotional needs of student, however, time is short and students are many. Meeting the needs of all 250 plus students within one academic year is unrealistic – *if* we view the role of counselor from a singular perspective. Collaborate, collaborate, collaborate. Collaborating with teachers can take many forms – the one I will address here is collaborating with teachers to provide an emotionally supportive and genuine classroom environment. Teachers want their classrooms to be productive and manageable; students essentially want to be in a hassle-free environment. Establishing respectful, appropriate relationships with the students provides the foundation for this type of classroom. However, we can be working against the grain of a long established culture.

The General Teaching Counsel of England’s *Research for Teachers* publication of October, 2008 illustrated this long established perspective. “There’s an old saying in teaching, 'Don’t smile before Christmas' (meaning don’t show your nice side before you’ve shown them who’s boss’), but Carl Rogers’ work led him to believe passionately that teachers should do precisely the opposite. He believed that teachers should seek to create emotionally warm, supportive environments in which they worked collaboratively with their students to achieve mutual goals. In such environments, he suggested, students came to “love” learning. His beliefs, expressed in his book *Freedom to Learn* (1969), were underpinned by years of experience as a counselor and supported by research evidence.”

Counselors - work with the teachers. Help them establish routines in their classroom that facilitate student-teacher relationships of respect. For example, a teacher can meet the students at their door,

greet them and make eye contact. Establishing this routine will take time, it will take effort and it will take a bit of adjustment for both the student and the teacher. Teacher-counselor collaboration also gives the counselor an opportunity to be actively involved in the day-to-day operation of the school day. Rather than being seen as the “*counselor*” – become an integrated part of the teachers and students daily routine. Through collaboration with teachers, counselors get into the classroom, join the discussion, and become familiar with the curriculum and the teacher’s teaching styles. As Oliver Twist said “become part of the furniture!” The counselor’s person-centered way to being can be transmitted to others in the community through suggesting and supporting such endeavors.

Parent-Counselor Collaboration

It’s all about the relationship. School counselors should – yes, I did say, *should* – introduce themselves to the parents at the Back-to-School nights. Get to know the parents at events and school activities that are educational or fun. Communicate information of interest to the parents. Be a resource. The primary goal of these activities is to provide information, educate and help establish a community. A secondary gain to these endeavors is that you are establishing a relationship with the parents. Establishing this relationship on an even playing field provides both you and the parents the opportunity to get to know each other and develop a mutual understanding and respect. This sets up the entrée for parents to contact you for information, appropriate support, and collaboration.

Because often - counselors meet parents on one of the worst days of their lives. And, if not the worst day, certainly not a high point in the week of this parent, this student, this family. Collaboration begins with establishing a relationship and bringing to the table unconditional positive regard. We cannot know what the student – and child of this parent – is experiencing or has done, but we do know is that this very vulnerable parent needs to be heard. Frequently, parents report a fear of being judged. Does the school think I’m a bad parent, that I don’t care about my child, that I haven’t taught my child the necessary life lessons? Implement the therapeutic attitudes of

congruence, unconditional positive regard and empathic understanding. This is an opportunity for a person-centered counselor to truly be the counselor we all aspire to be.

Administrator-Counselor Collaboration

The fundamentals of person-centered counseling provides the school counselor with a framework that is theoretically consistent with the demands of the school environment and the needs of the students. Rogers (1977) describes counseling as a process of freeing a person and removing obstacles so that normal growth and development can proceed and the client can become independent and self-directed. Clearly, the counseling process as presented by Rogers is consistent with the goals of today's educators. These goals are best facilitated through administrator-counselor collaboration.

Working with the administrators to establish a culture of respect is a key component to establishing a successful person-centered counseling program. Interestingly, the initial steps in this process are to respectfully gather information about the current culture. Once the counselor has a clear understanding of the mission of the school district, they can identify ways in which the role of the counselor can be more effectively integrated into the school's decision making process. Through collaboration with the administration, the counselor can become part of the process as the school district identifies and/or clarifies the vision and future plans for the school district. Making sure you have a place at the table during planning will facilitate development of an authentically person-centered environment. Importantly, ask what change is being considered, and how the administration envisions the role of counselor in this process.

Defining the role of a counselor is also another important aspect of collaborating with administrators. In a school setting, the role of counselor can lack clarity. I often hear from counselors that when a student was asked to come to their office the first thing the student asked was "Am I in trouble?" How sad. The role of counselor should be clearly understood by the students, faculty, parents and administration. Students should know that although we collaborate with teachers and administrators, counselors are not part of

the discipline process. Counselors may be sought out as advocates for students in the disciplinary process, but the role of counselor is set apart from the disciplinary process of the school. Work with administrators to clarify the role of counselor and the need for students to have a safe place to talk in a very complex system.

Take Away

As a person-centered counselor – lead with your way of being. Be transparent. Be respectful and accepting. Be truly empathic. In busy counseling offices, basic relational skills can get lost in the chaos and “walking the walk” of the person-centered orientation can get – let’s say – misplaced. Ask yourself: Do I care for myself so that I can genuinely care for others? Am I “doing my own work”? We can only be as genuine as our own journey.

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Nonviolent Communication: Tools and Talking-Points for Practicing the Person-Centered Approach

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I see the process of Nonviolent Communication (NVC) as being a set of tools to aid one in practicing the Person-Centered Approach (PCA) within interpersonal relationships. The great value of NVC as I see it is that it enables one to take the PCA, which is usually looked at in a very theoretical way, and make it into a very practical thing that anyone can do. I see great potential for Nonviolent Communication being used to assist in the real-life applicability of the Person-Centered Approach in more and more diverse situations.

I will briefly examine here some of the key points of the Person-Centered Approach, with a particular emphasis on Carl Rogers' 1956 document entitled "The Necessary and Sufficient Conditions of Therapeutic Personality Change", and relate each to their complementary practices that exist within Nonviolent Communication.

The Origin of Nonviolent Communication

Nonviolent Communication was first developed by Marshall B. Rosenberg, Ph.D. Rosenberg was a student of Carl Rogers at the University of Wisconsin-Madison during the 1957–1963 time-period. Rosenberg cites Rogers as being a major influence in the development of his work. Towards the end of their time together they were also colleagues working on the Wisconsin Project. In 1966, Rosenberg was awarded diplomate status in clinical psychology from the American Board of Examiners in Professional Psychology.

The process of Nonviolent Communication came into being through Marshall Rosenberg's work in the 1960s providing mediation and communication skills training for communities working to peacefully desegregate schools and other public institutions. In the

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1980s an organization was created, the “Center for Nonviolent Communication,” to provide structure and coordination for all of the Nonviolent Communication training that was taking place worldwide.

**Applying Nonviolent Communication Practices to Carl Rogers’
“Necessary and Sufficient Conditions of Therapeutic Personality
Change”**

Here is what Carl Rogers (1957/1989) wrote about the necessary and sufficient conditions of therapeutic personality change:

“For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

- Two persons are in psychological contact.
- The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
- The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
- The therapist experiences unconditional positive regard for the client.
- The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
- The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow.”

I will now elaborate on how Nonviolent Communication provides specific practices and means to assist one in creating each of

these six conditions mentioned above. I will begin by discussing the three conditions which Rogers refers to as the “core conditions,” which are “authenticity, empathy, and unconditional positive regard.”

Authenticity

Nonviolent Communication has two practices to help bring out authenticity (aka “congruence”) within a relationship. The first is what is called “self-empathy.” This consists of stopping and asking yourself what you are feeling and what you are needing within a given situation. It is a form of “giving yourself empathy”, genuinely listening to yourself to discover what your emotional feelings really are and what needs are motivating them.

The second practice is referred to as “honest expression”. Traditionally this is presented as someone first saying what is observed (i.e., what is specifically said or done) without any evaluation or interpretation mixed in. Then the speaker says what feelings and needs come alive for them when that observation happens. This expression of one’s own feelings and needs is where it is useful, perhaps even essential, for the speaker to go through a self-empathy process first before honestly expressing to the other person. Finally the speaker gives a clear and doable request to the other person describing what specifically could be done to better meet the needs expressed.

Empathy

The practice of empathy within Nonviolent Communication consists of attentively listening to someone with an active curiosity towards what the speaker could possibly be feeling and needing. This kind of listening could be done silently, or it could involve verbalizing guesses of possible feelings and needs to ask the speaker.

Within Nonviolent Communication empathy is something that is focused on to such a great extent that it exists as a specific practice that NVC practitioners often arrange to set aside specific times to practice exclusively. In addition to this empathy is also seen as an element that can exist within all interpersonal interactions, the presence of which it would be beneficial to increase. The NVC practice of

empathic listening (often referred to as “giving empathy”) is explicit, intentional, learnable, and resources are available to support the development of this skill.

New social forms have developed within the NVC community to support people’s empathic listening skills. For example, there is the “empathy buddy” one-on-one partnership relationship where individuals take turns empathically listening to the other person and being empathically listened to. There is also the “empathy group” relationship where a whole group of people takes turns empathically listening to an individual.

Unconditional Positive Regard

An important differentiation within NVC is made between “heart-open” and “heart-closed” communication, i.e., “is your heart open, or is it closed?” The phrase “heart-open” is synonymous with “unconditional positive regard,” whereas “heart-closed” is synonymous with “conditional positive regard.” Various practices extant in NVC are being developed to discern whether one’s heart is open or closed.

If one is holding judgments of another person, if one’s regard is given “conditionally,” then there is a process within NVC called the “Translating Enemy Images” process. This process involves learning your judgments of another person, seeing what demands you may hold of them, and reviewing your thought process therein. Then the NVC process of discerning “Observations,” “Feelings”, and “Needs” is used/applied both to yourself and in guesses about the situation of the person being judged. Eventually, through this process, the judgmental thinking (aka “enemy images”) is transformed into greater clarity and care for both yourself and the other person.

Another practice of unconditional positive regard is expressions of gratitude and appreciation to another person. These expressions can be aided with the NVC process through containing within the expression reference to the actions that have been done, the specific needs that have been met by these actions, and the positive feelings that arise as a result of all of this.

The Client’s Perception of the Core Conditions

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There is a means within Nonviolent Communication to gain a sense as to whether the person you are interacting with perceives you as being authentic, empathic and caring. This is through using what are referred to as “connection requests.” These kinds of requests are focused primarily on the relationship itself in the present moment. Examples of connection requests can be things like “how do you feel hearing me say that?” “Can you tell me back what you just heard me say?” “Do you trust that I mean what I’m saying here?” Based on how the person replies to these you then have more information to work with to better access whether the other person perceives the core conditions as being present within the relationship.

Anxiety and Fear in the Client

One concept that is used within Nonviolent Communication is that of “edges” and “working with your edges.” An “edge” is the area where one’s comfort regarding looking at and talking about a personal matter suddenly shifts. This is where a personal area then becomes “too personal,” “too dangerous,” “scary,” etc. The “edge” is where one’s “comfort zone” meets “out of one’s comfort zone.” Various practices exist to identify these areas and to experiment with them.

Another concept and practice within Nonviolent Communication is referred to as “walking towards your fear.” This is done through first identifying something which one is habitually afraid of and then identifying a specific individual who epitomizes that which one is afraid of. After that is done then one approaches that specific individual and initiates a conversation with them. Throughout this conversation one tries as best one can to be authentic, empathic and caring, while also offering clear doable requests for what could be done to improve things.

A third concept within Nonviolent Communication that is related to this area is that of “scary honesty.” What this refers to are those things that are on one’s mind and one is aware of, but which one is too afraid to verbalize. Saying what is on one’s mind here would be honest, but it is also “scary” to do so. Developing a practice of

conjuring up the courage necessary and then proceeding to say these things is engaging in a practice of “scary honesty.”

Psychological Contact

What is referred to by Carl Rogers as “psychological contact” is referred to in Nonviolent Communication as “heart-felt connection”. Within NVC establishing “connection” is highly valued, with many practitioners seeing it as being the entire purpose of it all. To quote the renowned NVC trainer Robert Gonzales:

“The primary intention of NVC is to create a quality of connection in which everyone’s needs are equally valued and met through natural giving.”

Similar to the other qualities mentioned above, various practices exist within NVC to discern and strengthen the quality of connection between individuals.

Additional Person-Centered Approach Key Concepts

The Actualizing Tendency

NVC has a core belief that everything that people do is an attempt to meet some kind of fundamental human need. A fundamental human need is distinct from a strategy to meet needs, in other words, it is independent of any particular person, place, thing, or action. For example, “love,” “acknowledgement,” “understanding,” “accomplishment,” “belonging,” etc., are fundamental human needs, whereas “Mr. Smith,” “sitting next to me,” “reading a book,” “winning the prize,” and “having a membership card” are all strategies to meet needs and are not considered needs themselves.

The actualizing tendency can be seen then as being the basic drive that each person has to meet needs. The actualizing tendency is not the same thing as fundamental human needs, it is instead the basic urge that one has to have needs met. I believe that viewing things this way helps to give a clearer picture of how the actualizing tendency interacts with our day-to-day life.

Personal Power

I see Nonviolent Communication as relating with personal power in two ways. First, it strengthens the ability of each person to see the world in terms of concrete observations and do-able requests that are separate and distinct from interpretations and evaluations. Seeing the world as it is apart from people's thoughts about it I believe helps one to have more of a full understanding as to what actually exists that could be used to potentially meet needs. Secondly, NVC strengthens the ability of each person to be aware of the moment-by-moment choices that they make as attempts to meet particular needs. Once one is aware of which needs one wants to have met in a given situation, then one can re-evaluate one's course of action and chose that which they think is most likely to result in those needs being met.

Nonviolent Communication as a Modern PC Approach

Teachable

There are very specific places to focus one's attention on. For example, you can focus on "observations," "feelings," "needs," or "requests" in a number of different ways. You can focus on them in terms of how they relate to you in the present, past, or future, or in terms of another person, or you can focus on them in terms of the thoughts that you have about another person. With the assistance of a skilled practitioner one's attention can be repeatedly directed to areas where NVC concepts and practices can be applied. You can also break NVC down into bite-size "chunks." For example, "observations," "feelings," "needs," or "requests" can each be focused on individually until one feels comfortable enough with each concept before proceeding on to another one. One does not need to fully understand the other concepts in order to find value in working with one of them.

Learnable

There are specific step-by-step processes that can be applied for practice and learning. These processes can be gone through repetitively until one develops new habits around using them. Also,

each step can be checked to make sure that it is actually accomplished correctly. For example, there are ways to check to make sure that a request is actually a request, to check that an observation is actually an observation, a need a need, etc.

Demonstrable

The Nonviolent Communication process can be embodied at will by people who are trained in it and who make the choice to use it. Situations where the process is demonstrated by one or more persons using the NVC process can be role-played by people trained in it.

An Invitation to You

For the sake of developing your own skill and proficiency in creating the six conditions that Rogers spoke of as being necessary for constructive personality change, I invite you to investigate more about Nonviolent Communication.

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Appendix

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Nonviolent Communication Quick Reference Guide

Expression	Empathy
Observation <i>When I see/hear . . .</i>	[Observation] <i>[When you see/hear . . .]</i>
Feeling <i>I feel . . .</i>	Feeling <i>Are you feeling . . .</i>
Need <i>Because I need . . .</i>	Need <i>Because you need . . .</i>
Request <i>Would you be willing...?</i>	[Request] <i>[Would you like...?]</i>

Observations: Description of what is seen or heard without added interpretations. For example, instead of “She’s having a temper tantrum,” you could say “She is lying on the floor crying and kicking.” If referring to what someone said quote as much as possible instead of rephrasing.

Feelings: Our emotions rather than our story or thoughts about what others are doing. For example, instead of “I feel manipulated,” which includes an interpretation of another’s behavior, you could say “I feel uncomfortable.” Avoid the phrasing: “I feel like . . .” and “I feel that...”- the next words will be thoughts, not feelings.

Needs: Feelings are caused by needs, which are universal and ongoing and not dependent on the actions of particular individuals. State *your need* rather than the other person’s actions as the cause. For example, “I feel annoyed *because I* need support” rather than “I feel annoyed *because you* didn’t do the dishes.”

Requests: Asking concretely and clearly for what we want (instead of what we don’t want). For example, “Would you be willing to come back tonight at the time we’ve agreed?” rather than “Would you make sure not to be late again?” By definition, when we make requests we are open to hearing a “no,” taking it as an opportunity for further dialogue.

Empathy: In NVC, we empathize with others by guessing their feelings and needs. Instead of trying to “get it right,” we aim to understand. The observation and request are sometimes dropped. When words are not wanted or are hard to offer, empathy can be offered silently.

Self-Empathy: In self-empathy, we listen inwardly to connect with our own feelings and needs. It is that connection which enables us to choose our next step.

A List of Some Fundamental Human Needs

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<p>Physical Survival</p> <p>air nutrition food waste water sleep shelter movement safety rest chemical balance sexual expression</p>	<p>Nurturance</p> <p>touch closeness physical affection sensitivity warmth intimacy relaxation tenderness caring bonding comfort love</p>	<p>Autonomy</p> <p>freedom space independence will choice fortitude individuality stamina self-empowerment options solitude</p>
<p>Mental</p> <p>stimulation focus clarity / to understand comprehension discernment belief information memory awareness reflection perspective discrimination</p>	<p>Self-Expression</p> <p>creativity to be heard growth speaking healing singing learning / mastery meaning teaching to create / generate</p>	<p>Integrity</p> <p>self-worth centeredness authenticity identity self-respect composure purpose conviction vision / dreams direction honesty dignity</p>
<p>Celebration of Life</p> <p>aliveness ecstasy pleasure delight accomplishment stimulation excitement dance humor passion intensity play to celebrate losses: mourning loved ones, dreams unfulfilled, etc.</p>	<p>Spiritual</p> <p>beauty / aesthetic bliss harmony / peace self-awareness order serenity grace faith inspiration hope communion being / beingness higher purpose transcendence</p>	<p>Interdependence/Social</p> <p>acceptance trust companionship empathy appreciation cooperation belonging community contribution to others acknowledgment reassurance connection group identity respect communication consideration support honesty from others emotional freedom understanding emotional safety</p>

Person-Centered Therapy, Masculinity, and Violence

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When it comes to best practices in therapy, there is no one-size fits all, but the person-centered approach can apply to many. The current paper examines the applications of the person-centered core conditions to working with client issues of masculinity and violence.

The Person-Centered Relationship

The person centered approach focuses on the therapist's attitudes and the client's perceptions of those attitudes, and can be applied to a variety of clients with a variety of problems. Carl Rogers believed that a therapeutic relationship must develop between client and therapist for the counseling process to be effective. He also maintained that the person centered therapist must be fully integrated in the client/therapist relationship (Kirschenbaum, 2007). This relationship creates a safe climate for the client to journey from a state of incongruence, or inconsistency between internal and external world, to one of self actualization and full functioning.

In person-centered therapy, clients recognize capacities within themselves, and move toward self actualization and congruence. The therapist's part in relationship building "...calls for a total sensitivity to the client in his own perspective and the communication of this kind of acceptance and understanding..." (as cited in Kirschenbaum, 2007, p. 156). "To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard" (Rogers in Kirschenbaum, 2007, p. 193).

Rogers modified his views about the therapy process throughout his career. In discussing Rogers' evolving view on the importance of therapist attitudes, Kirschenbaum (2007) states, "...in

modifying these attitudes, he came to believe that, even more important than the therapist simply holding these attitudes, the attitudes must be lived and experienced by both therapist and client in a genuine, interpersonal relationship” (p. 195). “It is only as he is, in this relationship, a unified person, with his experienced feeling, his awareness of his feelings, and his expression of those feelings all congruent or similar, that he is most able to facilitate therapy” (as cited in Kirschenbaum, 2007, p. 189).

Therapy Seeking by Men

It is estimated that about one in seven men seek psychological services, and that “women tend to use the mental health system more often than men” (McCarthy & Holliday, 2004, p. 26). In evaluating gender expectations of therapy, Apfelbaum reported that males expected a more directive type of counselor, while females expected a more client-centered type of counselor (as cited in Cashen, 1979, p. 680). Gender role socialization theory has been used to explain gender differences in psychological service-seeking. Levant defined gender role theory as the processes of male socialization into a culturally defined structure of gendered beliefs to which men are expected to adhere (as cited in Gillon, 2008, p. 123). The normative male gender role encourages an externalizing, acting-out mode of being. Emotional distress is often manifested by males through destructive behavior, such as violence, substance abuse, and risk-taking.

According to Robertson (in Gillon, 2008), the implications of gender role conflicts on masculinity can be found in men’s physical and mental health difficulties, particularly in their lower levels of participation in psychotherapy. “Traditional counseling requires men to set aside much of their masculine socialization simply to get through the door and ask for help” (as cited in McCarthy & Holliday, 2004, p. 26). Entering counseling can be scary for both males and females. The very nature of letting one’s guard down and becoming emotionally available to a counselor or therapist goes against the traditional male role. According to Scher (1979), men are expected to be powerful and in control of themselves and their situations at all times. Seeking

psychological services indicates the need for help, which may be difficult for those who adhere to the traditional male role.

Although gender role socialization still exists, gender roles have drastically changed over the past fifty years. Challenging role socialization theory, Addis and Mahalik (2003) suggest that individual men are capable of different behaviors depending on the context. Men who adhere to traditional masculine roles may cry, and non-traditional men may act in a destructive manner, such as making a homophobic remark (as cited in Gillon, 2008, p. 124). Additionally, the social constructionist approach views men as actively constructing the meaning of their masculinity in the moment, rather than as a fixed product of gender role socialization (Gillon, 2008). Other alternatives to role socialization theory shift the focus from individual masculine identification to the cultural domain in which men negotiate and renegotiate their identity.

Person-Centered Therapy and Masculinity

Because gender accounts for a large part of an individual's identity, it is worthwhile to ask how gender identity is approached from the person centered perspective. According to Wolter-Gustafson (2008, p. 101), "the person-centered approach already allows each person to find their unique way of making sense of their experience without gender-based preconceptions." Rogers "demonstrated that the actualizing tendency of the organism seeks to operate as a whole" (Wolter-Gustafson, 2008, p. 100). He affirmed the uniqueness of each male, female, and transgendered person without consideration of their sexual orientation. Through his genuine acceptance of each individual as a whole, rather than separate aspects of their identity, Rogers challenged the hierarchy of gendered binarism. Wolter-Gustafson (2008) stated, "gender binarism, the assumption that there are two opposite genders, is a construction well encoded in language" (p. 99). In a case of binary division, one side is valued more than the other, creating categorical conditions of worth.

It is reasonable to assume that many clients may be affected by gendered conditions of worth, although there is disagreement among person centered practitioners as to how gendered personhood should

be adequately accounted for. The person centered approach associates with traditional female characteristics, such as interpersonally relating with empathy and nonjudgmental caring. Scher (1979) suggests that counselors should carefully consider male reluctance to engage in the counseling process, and to be aware of male need for power and control. Rather than the therapist addressing gender as it relates to the client, Bozarth suggests gender become relevant in the client centered process only if introduced by the client (as cited in Wolter-Gustafson, 2008, p. 102). If the person centered therapist is practicing empathic understanding and perceiving the client for who they truly are, the relevance of gender will become apparent through the client's being.

Successes in Therapy with Violent Male Clients

Research on therapy with violent men has yielded some documented successes. Cognitive behavioral techniques have “helped men alter their problematic thinking, control their aggression, and use strategies to cope with negative feelings such as anger, jealousy, insecurity, and low self-esteem” Weaver (2008, p. 176). Cognitive behavioral therapy was effective in restructuring cognitive distortions that men held in relation to women, and in reducing the use of violence to resolve conflict. But documented success using cognitive behavioral therapy with violent men is limited and inconclusive, and the actual process that makes specific interventions effective is lacking (Weaver, 2008). Though male perpetrators may leave cognitive behavioral counseling with learned tools to change cognitions, Gadd (as cited in Weaver, 2008, p. 176) suggests that if interventions only work at the cognitive level, they risk failing to engage in more emotionally embedded aspects of violent masculinities which often shape men's use of violence and control and their sense of themselves as men. Men's engagement in the counseling process is likely to be low in a relationship that is confrontational and unresponsive to their deeper needs. Without a genuine understanding of the client and a strong psychological relationship between the client and therapist, the client can easily participate at a superficial level without ever reaching a deeper process of self understanding and transformation (Weaver, 2008).

Person-Centered Therapy with Violent Male Clients

Rogers was careful to point out that the necessary and sufficient conditions for personality change may not apply to all types of clients. He stated that while these conditions are necessary for client centered therapy, other conditions may be necessary for other types of therapy. Seeking to discover whether certain types of clients benefit more from the person centered approach than others, Weaver (2008) found little research on the person centered approach in regards to specific clientele. Cooper has suggested that the paucity of research on person centered therapy with specific client populations may be due to the reluctance of person centered practitioners to categorize clients according to pre-defined diagnostic indicators (as cited in Weaver, 2008, p.175). Rogers emphasized the person and rejected categories, since categorizing tends to make people feel as incongruent as they did before entering the therapist's office.

Person-centered therapists value continuous self-awareness of prejudices that may block empathic attunement to their client's experience, and realize that being genuine depends on seeing clients from their internal frame of reference. Person-centered attitudes are challenging to hold when the client is a male perpetrator of abuse and violent acts against women. Male perpetrators of violence are often repeat offenders. Brief programs designed to address their violent attitudes may be ineffective, and ultimately allow them to continue destructive behavior. Destructive behaviors are symptoms of deeper problems within individuals, which, if addressed within the safe environment of a person centered approach, could result in long lasting changes.

The person centered approach might be particularly effective in producing long-lasting change in male perpetrators of violence, but building person-centered relationships with violent men is a difficult task. Weaver (2008) points out that this difficulty is compounded by an urgency to help quickly due to the danger the individual poses to others. Understanding the masculine social context from which men's violence stems may help, and the concept of *hegemonic masculinity* (Connell, 1995 in Weaver, 2008) is a useful concept for this purpose. Hegemonic masculinity stresses the dominance of traditional modes of

masculinity over others within Western cultures. In exploring the implications of the concept for the establishment of a person-centered therapeutic relationship, Connell (in Weaver, 2008) begins with four main facets of hegemonic masculinity: power, ambivalence towards femininity, domination and objectification, and avoidance of emotion. Hegemonic masculinity raises important considerations about the PC relational conditions of psychological contact and client incongruence. Hegemonic masculinity recognizes that men are culturally apt to avoid therapy because of feeling that seeking help indicates weakness. This avoidance prevents the prerequisite client-therapist psychological contact and minimizes potentials for development of a therapeutic relationship. The precondition of incongruence, and the requirement for the client to be vulnerable and anxious, has implications for person centered therapy working with male clients.

Connell (in Weaver, 2008) suggests that the terms of person centered therapy align more to feminized than masculinized identities. Wilkins (as cited in Gillon, 2008, p. 126) points out that clients whose therapeutic process is affected by hegemonic masculine identity can relate in therapy under certain conditions. For example, men who enter counseling as required by a female partner or employer, rather than as a self identified need, seem more amenable. Perhaps it is the monumental consequences—divorce, loss of job-- that awakens the client into “submission.” Accepting their position of relative weakness and need for help, the person centered therapist is cautioned to proceed carefully in the case that some hegemonic masculine clients may require another individual to initiate the help seeking for them.

The communication of empathy is crucial to the person centered approach to hegemonic masculinity. Hegemonic masculinity encourages men to think and do rather than feel. The empathic process presents a challenge for both the therapist and the client. Both parties may be working towards different goals, the therapist focusing primarily on the emotional experiencing and the client perceiving a failure to think or do rather than an empathic understanding of their true being. Essentially, the person centered efforts to experience the client may be lost in translation.

Gillon (2008) suggests that many of the therapist’s experiential responses or emotional questions done so to introduce emotional

experiencing may invoke feelings of shame that could undermine the client's experience of the therapist's unconditional positive regard. To be truly empathic and sensitive to the implications of hegemonic masculinity may require the person-centered therapist to move away from emotional experiencing. This raises an ethical and personal dilemma for the person centered therapist, presented with a decision contradictory to making emotional contact and facilitating emotional experiencing to support change. The male client who adheres to hegemonic masculinity is likely to challenge the therapist to make ethical decisions about the sufficiency of the core conditions in light of violence and non-emotionality. Gillon (2008) presented different approaches to working with male clients, specifically some of the challenges in the relationship between person centered therapy and masculinity.

It is important for counselors to understand the implications of gender as it relates to the individual's being and identity. Wolter-Gustafson (2008) contends that "we need to cast a wider net of empathic understanding to include the normative and contextual givenness of our clients' lives, and our own" (p. 106). It is the intention of the person centered therapist to apply Rogers' conditions to each individual client, including a perpetrator of assault. While use of the person centered approach vis-a-vis masculinity presents certain challenges, person-centered therapy has some unique advantage in helping masculinized and/or violent male clients overcome some of the destructive behaviors of the normative male gender role.

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Summary and Evaluation of Carl Rogers' Necessary and Sufficient Conditions of Therapeutic Personality Change

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The Necessary and Sufficient Conditions

Carl Rogers (1957) posited six necessary and sufficient conditions of therapeutic personality change. He proposed that “if all six conditions are present, then the greater the degree to which Conditions 2 to 6 exist, the more marked will be the constructive personality change in the client” (In Kirschenbaum, 2007, p. 830). Rogers’ six conditions appear in *The Necessary and Sufficient Conditions of Therapeutic Personality Change* (1992) as follows:

- 1) Two persons are in psychological contact.
- 2) The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
- 3) The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
- 4) The therapist experiences unconditional positive regard for the client.
- 5) The therapist experiences an empathic understanding of the client’s internal frame of reference and endeavors to communicate this experience to the client.
- 6) The communication to the client of the therapist’s empathic understanding and unconditional positive regard is to a minimal degree achieved (p. 827).

Condition 1: Psychological Contact

Rogers’ first condition is hypothetical. Client change outside of the context of a relationship may be possible, since Rogers’ research presumed the presence of a client-therapist relationship. Alternatively,

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people can naturally evolve and change without direct influence from others. Accordingly, Bozarth (1988) proposes that the core conditions are “not necessarily necessary, but always sufficient.”

Condition 2: Client Incongruence

The second condition identifies incongruence as the state of being that compels the client to seek therapeutic intervention. Rogers (1957, p. 828) defines incongruence as “a discrepancy between the actual experience of the organism and the self picture of the individual insofar as it represents that experience....” Furthermore, “...there is a fundamental discrepancy between the experienced meaning of the situation as it registers in his organism and the symbolic representation of that experience in awareness in such a way that it does not conflict with the picture he has of himself.” When a person perceives their incongruence, a state of anxiety is produced and they may wish to seek help.

Condition 3: Counselor Congruence

The third condition establishes that the therapist must strive to be congruent in the therapy relationship. Congruence is a stable and balanced state of self-experience and self-perception. Experience and self-awareness depend upon one another, while genuineness expresses that interdependency. Congruence is “a therapeutic attitude of genuineness or wholeness...a state of integration in which self-experiences are accurately symbolized and which, if true of all self-experiences all the time, would lead the individual to being a fully functioning person...” (Tudor & Merry, 2006, p. 29).

Rogers thought therapists should be as genuine as possible during therapy. Genuineness involves attempting to not put on facades for the client. Rogers moreover considered the therapeutic relationship to be the most important part of effective therapy. “It is not necessary (nor is it possible) that the therapist be a paragon who exhibits this degree of integration, of wholeness, in every aspect of his life” (Rogers, 1957, p. 828). However, therapeutic relationships can be compromised by a less than fully functioning therapist. “...Rogers (1959) suggests

that openness to experience, psychological adjustment, extensionality and maturity, all derive from the concept of congruence” (Tudor & Merry, 2006, p. 29).

Rogers (1957) considered “congruence - the ability of the therapist to be his or her true feelings – the most essential of the essential conditions. Neither positive regard nor empathy could be meaningful, he thought, ‘unless they are real, so I must first of all be integrated and genuine within the therapeutic encounter’” (Rogers & Woods, 1974, p. 236). A recent formulation on the significance of congruence is provided by Klein, Kolden, Michels, and Chishold-Stockard (2002), who discuss congruence as a needed prerequisite of unconditional positive regard and empathy.

Condition 4: Unconditional Positive Regard

The fourth condition emphasizes that the therapist must endeavor to have unconditional positive regard (UPR) for the client. On unconditional positive regard, Rogers (1957, p. 829) says, “It means a caring for the client, but not in a possessive way or in such a way as simply to satisfy the therapist’s own needs. It means a caring for the client as a separate person, with permission to have his own feelings, his own experiences.” Other terms utilized in reference to UPR include warmth, respect and even love. Unconditional positive regard is not a technique or skill that a therapist can acquire, but a system of values and an integrated part of the person.

Unconditional positive regard helps to foster a foundation of trust that enables the therapeutic relationship to flourish. Tudor and Merry (2006) define UPR as “a consistent acceptance of each aspect of a person’s experience...it involves feelings of acceptance for both so-called ‘positive’ and ‘negative’ aspects of a person, and can be expressed as non-possessive caring for a person as a separate individual” (p. 146). Clients should “experience UPR as a quality exhibited by their therapist that makes it possible for them to express any part of themselves and their experience without the fear that they will be judged as persons” (Tudor and Merry, 2006, p. 146).

Condition 5: Empathy

In the fifth condition, the therapist attempts to understand the client's world from the client's internal frame of reference, and communicates this experience to the client. Empathic understanding comes from grasping the true meanings of experience within the client's perspective. "To sense the client's private world as if it were your own, but without ever losing the 'as if' quality...to sense the client's anger, fear, or confusion as if it were your own, yet without your anger, fear, or confusion getting bound up in it" (Rogers, 1957, p. 829).

According to Donner (1991, p. 53), "in any therapy in which relationship serves as the crucible for change, *empathy is imperative*, as it is the connection which sparks the relationship [italics added]. Without empathy there is no meaningful relationship and no access to experiences and data by which the self becomes known. Only empathy can offer a convincingly safe invitation to a meeting attended by patient and therapist in which the subjective world of the patient creatively unfolds. As such, empathy is a prerequisite for all other therapeutic interventions."

Rogers addressed empathy as three ways of knowing: subjective, interpersonal, and objective. Within the subjective way of knowing, individuals have capacities for empathic understanding of their own internal frame of reference. They attempt to comprehend implicit meanings of experience in the interactions between individual and external stimuli and cues. In interpersonal knowing, "The direction of an individual's empathy is toward another person in an effort to grasp his or her phenomenological functioning. In a therapeutic context, a counselor or therapist momentarily restrains one's own subjective views and values when the focus is on a client's frame of reference" (Clark, 2004, p. 143). Finally, in the objective way of knowing, empathic understanding is directed toward groups who have a frame of reference that is external.

"Rogers recognized the importance of an objective way of knowing with respect to highly regarded advances in science and technology, and he cites examples from physics and psychology that involve inherent human qualities and limitations in the pursuit of

objective knowledge” (Clark, 2004, p. 143). But Rogers advocated most strongly for the interpersonal way of knowing, because he believed that it was interpersonal knowing that cultivated a psychologically safe environment where the client could be encouraged to share perspectives from his or her own frame of reference.

Condition 6: Communication of Conditions Achieved/Perceived

Rogers (1959) postulated that it is enough that the therapist demonstrates empathy toward the client’s internal frame of reference and the client perceives the empathic understanding. Ways therapists can receive and convey understanding are potentially infinite, and may involve bodily movements, attentiveness, and eye contact toward the client. The therapist can verbally reaffirm what the client is saying by using reflective statements, which serve as mirrors of the client’s experience. Reflective statements also help the client to clarify further a statement or feeling.

Ruth Sanford (personal communication with Jo Cohen Hamilton June 17, 2009) posited that unconditional positive regard, empathy and genuineness are not separate conditions, but that these three concepts are intertwined. Rogers thought that the therapeutic process could not be initiated unless all of the conditions work off each other to allow the maximum potential of the client to be realized.

The sixth condition ties unconditional positive regard and empathic understanding together as the therapist successfully communicates these therapeutic interventions to the client. Rogers (1957) posited “The client perceives the acceptance and empathy which the therapist experiences for him. Unless some communication of these attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned” (p. 830).

Praise and Criticism of the Core Conditions

Wachtel

Wachtel (2007, p. 280) considers Rogers’ true aim to contrast with psychoanalysis. It was “not to enable the client to see what he or

she had been unconsciously thinking and feeling all along if only he or she could acknowledge it, but rather to develop the thoughts and feelings that were incipient but blocked by anxiety and self-disparagement.” Wachtel (2007) also compares unconditional positive regard to the psychoanalytic concept of neutrality. Neutrality means that the therapist does not make judgments on the client, nor direct the client in a specific direction, but instead aims at understanding the individual in his or her own terms. Because it is difficult to define and plagued by ambiguities, says Wachtel, neutrality is not as worthwhile a formulation for a therapeutic relationship as unconditional positive regard. Still, Wachtel (2007, p. 280) argues that “being in a relationship with the patient, while a crucial grounding condition, is necessary but not sufficient.”

Farber

According to Farber (2007) “while each of the conditions that Rogers postulated has been linked to positive therapeutic outcome, taken together they have never been conclusively proved (nor disproved) to be either necessary or sufficient for positive outcome” (p. 289). Farber notes that some of Rogers’ terminology was rooted in psychoanalysis, and that he referred to therapeutic outcomes as: “greater integration, less internal conflict, more energy utilizable for effective living; change in behavior away from behavior generally regarded as immature and toward behavior regarded as mature.” (in Farber, 2007, p. 290) Farber additionally notes that “Rogers specified ‘personality change; at both ‘surface and deeper levels’ as his therapeutic goal, which seems inconsistent with the essential client-centered notion of non-directiveness.

Hill

Hill (2007, p. 261) found a correlation exists in psychotherapy research, between the therapeutic relationship and outcome. The relationship may not be either necessary or sufficient for any kind of change, says Hill, but it makes a big difference in therapy. Hill (2007) cites Asay and Lambert’s research on the client’s active role in the

change process (about 40% of improvement in outcome is due to client variables). Three client qualities which seem especially helpful are: a self-healing ability, the willingness for change, and involvement in therapy. For Hill (2007), the concept of unconditional positive has conceptual concerns, is not a clearly defined construct, and seems to overlap with empathy and genuineness. Hill quotes Lietaer's 1984 position that "UPR and genuineness are parts of a more basic attitude of 'openness,' but that there is inherent tension between the two constructs in that therapists' own issues influence how much they can truly accept others, and it is impossible to be consistently and genuinely unconditional" (as cited in Hill, 2007, p. 262). Hill also points to Duan and Hill's 1996 observation that Rogers' use of the word sensing instead of feeling in regards to empathy (as cited in Hill, 2007), indicates a cognitive type rather than an emotional empathy or attunement to the client. Of course empathy cannot be the same for every individual client, and Hill (2007) speculates that "preferences for different types of empathy or alliance are based on attachment history...clients with an avoidant attachment history might prefer a distant relationship with a therapist, whereas clients who are insecure or dependent might prefer an extremely close therapeutic relationship" (p. 262). Such factors are not explicit in the person-centered approach.

Bohart, Elliott, Greenberg, and Watson

Bohart, Elliott, Greenberg, & Watson (2002) believe that empathy may lead to positive outcomes for numerous reasons. Because empathy increases client fulfillment with therapy, it may increase compliance with therapeutic interventions. It may give a curative emotional experience, which may allow clients to feel worthy of respect. Empathy promotes the client to explore feelings, may facilitate emotional re-processing, and may encourage clients' efforts for personality change.

Silberschatz

Silberschatz (2007) found that Rogers' six conditions were necessary for therapeutic initiation but not sufficient in all cases.

Silberschatz (2007) posited that while Rogers thought the relationship alone could determine the success of the therapy, the author found “although many patients undoubtedly benefit enormously from the therapist-offered conditions and relationship qualities that Rogers described, there are patients who require more technical approaches (e.g., interpretations, homework, relaxation techniques, mindfulness training, etc.)” (p.266).

Silberschatz (2007) also takes into account that it is not universally helpful for the therapeutic stance to be a warm, accepting and unconditional one, and at times it may turn out to be detrimental. Silberschatz (2007) also addresses that Rogers’ model did not consider patient factors in the therapeutic process of change. “Patients clearly differ in their abilities to utilize treatment, and such differences account – at least to some extent – for therapeutic changes. Patient factors such as motivation or readiness for change, level or quality of attachment style, reality testing, emotional regulation, and severity and chronicity of problems all play some role in predicting therapy outcome” (Silberschatz, 2007, p. 266).

Personal Reaction to Application of Theory

It was interesting to see an actual demonstration of client-centered therapy at the person-centered conference. The most marked was a situation in which the therapist used silence the entire time, which I believe worked because he knew his client very well and they were friends. The practical application of the theory and therapy were very beneficial to me. I was awakened to see different therapeutic styles of the therapists, all of whom considered themselves person-centered. One therapist was able to show empathy very well to her client as she continually reflected back what the client was saying. This was very helpful in aiding the client to express herself more fully, which helped the therapist to know if she was correct in understanding what the client was trying to express.

I learned quite a bit about intentionality at the conference. A lot of people seemed to get upset if they thought a therapist was not strictly practicing person-centered therapy. I don’t believe that Rogers would be so upset if a therapist used a multi-directional approach. The

person-centered theory is more about the positive therapeutic attitudes that the therapist should adopt if the therapy is going to be successful; not about specific techniques or procedures. Rogers (1957) posited that unconditional positive regard may never exist except within theory, and his concept of empathy was hard to measure and define. In my opinion, being person-centered does not mean strict adherence to one set of principles, but is a basic foundation and set of values. I believe that clients may benefit from cognitive or behavioral assignments, such as homework, and would have no qualms in utilizing these techniques. In utilizing various techniques, but still embodying the person-centered mind-set, I would not consider myself to be less person-centered. The most important aim of therapy is to help the client, after all. Some people think that person centered therapy does not have enough structure but I like the freedom the approach allows. It gives a quality of being able to adapt and change. I think the person centered theory provides this liberty compared to more rigid approaches to therapy.

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Inclusion as a Natural Extension of the Person-Centered Approach: Welcoming All Learners

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Abstract. *During my attendance at ADPCA, I could not help but reflect on the benefits that the person-centered approach offers special education. In my professional experience as a teacher and therapeutic staff support, I have often found myself wondering the best way to reach children, and how to help them truly learn. Turning to a collection of essays, papers, and talks given by Carl Rogers gave me a great deal of philosophical direction, and creative inspiration. Looking at research on inclusion, especially by those who advocate and assess the effectiveness of a learner-centered approach to education, the efficacy of the approach became clear to me. Coming away from the conference I felt excited to incorporate the person-centered approach into my future work as a therapist. I now feel prepared to incorporate this approach in my current education profession, and into my own personal life. This paper presents reactions to the 24th Annual Association for the Development of the Person Centered Approach (ADPCA) Conference held at Kutztown University in June, 2009. This paper shares my experiences and reflections on how education and inclusion have been influenced by the Person-Centered Approach, as well as how the Person-Centered Approach can continue to enrich and infill special education practices with life and energy. Case Illustrations.*

Inclusion is a natural extension of the Person Centered Approach. The basic premise of inclusion is that non-traditional learners do better when they are welcomed into the same community and classroom as any other learner. The debate in special education today rages on about movements in behavior modification, life skills classrooms, and the inclusion of special needs students (Wisconsin Education Association Council, 2009), Abosi summarizes that:

Education has three main roles: it is developmental because it develops the unique qualities of a child; it differentiates between learners because it treats every child as an individual, appreciating individual differences; and it is integrative because it accommodates people of varying backgrounds (culture, beliefs and values) thereby

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allowing for a cooperative approach in problem solving (Abosi, 2008).

Rogers on Education

Inclusion, or the practice of bringing non-traditional learners into the community of the typical classroom, is a most natural and meaningful application of the core conditions to special education (cf. Rogers, 1989, p.221). Rogers' perspective on the broken nature of the educational system in America appears in three papers published over the span of 30 years, including: *Personal Thoughts on Teaching and Learning* (1957), *The Interpersonal Relationship in the Facilitation of Learning* (1967), and *The Politics of Education* (Rogers, 1977/1989). It was Rogers' opinion that the core conditions exist in the typical realm of human relationships, but are much more essential in the therapeutic relationship in order to bring about any sort of change. He writes:

...the therapeutic relationship is seen as a heightening of the constructive qualities which often exist in part in other relationships, and an extension through time of qualities which often exist in part in other relationships, and an extension through time of the qualities which in other relationships tend at best to be momentary (Rogers, 1989, p.231).

Rogers' three essential qualities of person-centered educational relationships directly correspond to counselor qualities of genuineness, acceptance, and empathy in client-centered relationships. These include: 1) Realness in the Facilitator of Learning, 2) Prizing, Acceptance and Trust, and 3) Empathic Understanding (Rogers, 1989, p.306-311, from *The Interpersonal Relationship in the Facilitation of Learning* written in 1967). He states:

There are three conditions that constitute this growth-promoting climate, whether we are speaking of the relationship between the therapist and client, parent and

child, leader and group, teacher and student, or administrator and staff. The conditions apply, in fact, in any situation in which the development of the person is the goal (Rogers, 1989, p.135, from A Client-centered/Person-centered Approach to Therapy).

Psychological Contact and Inclusive Education

The person-centered relationship between a student and teacher must begin with “two persons in psychological contact.” In *The Politics of Education*, Rogers is critical of the teacher as leader and source of knowledge and power from which educational systems traditionally stem. He emphasized that a learning relationship is one of facilitation, not domination, and called for an egalitarian approach to heal the educational system, in contrast to the norm where “The teacher is the possessor of power, the student the one who obeys.”

Rogers draws a comparison between the medical model of therapy and the educational system as a hierarchy, “where power rules and democracy and its values are ignored and scorned in practice” (Rogers, 1989). In the hierarchy of education, the student is at the bottom of the totem pole, and the special needs student is lower still. I myself have heard reference to working with special needs students as “glorified babysitting” and see the results of this hierarchal system to be giving the typical student little power or respect, and the special needs student none at all.

During the ADPCA conference, I attended Jeffrey Cornelius-White’s presentation *Learner-Centered Instruction: The Evolving Model of Humanistic Education*, presented by. Cornelius-White emphasized how much more readily students learn when they are engaged and interested in the subject. A great deal of the engagement is due to a healthy sharing relationship between students and instructor. Cornelius-White’s own session was learner-centered; he went around the room and asked us each what we would be interested in learning about, and then spoke our areas of interest. I asked him his views on using learner-center/person-centered principles in a special needs setting. Cornelius-White felt it would be an enriching and

applicable area, yet felt he could not speak to it in specifically, since he himself has mostly worked with college students (ADPCA, 2009).

The second core condition that Rogers writes is, “The first, whom we shall term client, is in a state of incongruence, being vulnerable or anxious” (Roger, 1989). The presence of this condition is somewhat different in education than counseling, because a student comes for learning, or with the expectation to learn something from the teacher. Possibly anxious or vulnerable, in either case, a student is looking for the teacher to provide something.

Special needs students may be especially vulnerable or anxious, and feel out of place, undervalued, incompetent or misunderstood from in the past. Incongruence may exist in any student, but more so in students with different needs. Take for example, a young male student with a diagnosis of attention deficit disorder. The student has been repeatedly told, either through actions or directly, that he is different and not a good learner; even told he is a drain on the classroom. He may come to the educational experience with resentment, mistrust toward the teacher, and with feelings of inadequacy and frustration at his abilities, yet he still comes with expectations of what a teacher might provide him.

The authors of the article, *Supporting Students with Dyslexia at the Secondary Level: An Emotional Model of Literacy* seem to have a clear understanding of the impact that a student’s own perceived educational inabilities have on his or her emotional health. In the article, the authors encourage the reader to address the emotional consequences of dyslexia:

Consequently, providing appropriate learning opportunities should go far beyond teaching the mechanics of reading. It is the responsibility of teachers to support in a holistic way the personal development of students who need to overcome their dyslexia. [Many]...studies demonstrate the emotional “scars” of frustration, shame, and depression that can result from lack of identification and appropriate support for young people (Long, MacBlain & MacBlain, 2007).

Considering the emotional health of students, Long, McBlain and McBlain (2001) assert the paramount importance of student gains in emotional literacy and ability to express emotions about literacy, to the eventual achievement of reading competency. If a student becomes fearful of a subject, the fear itself can hold the student back from improvement in that subject. It is therefore essential to the student's growth, to acknowledge and ameliorate that fear while at the same time working to improve their academic skills.

Congruence and Inclusive Education

That "the second person, whom we shall term the therapist, is congruent or integrated in the relationship" (Rogers, 1989) also applies to being a good teacher. Teachers bring all their past experiences into the classroom. Very early on in my experience working in special education, I realized how much my own congruence impacted my ability to teach. If I was tired, angry, upset, happy, or distracted, it had a major impact on reaching my students. Not only that, but I also brought my own relationship with school, authority, and individual subject matter into the school with me.

Take a simple example from my experiences of math. I struggled with math throughout my educational experience to the extent that I still have little personal enjoyment or even interest in the subject. One day a young girl was conquering extra math sheets with gusto, she delightfully whipped through sheets that contained my least favorite of functions: multiplication. I was surprised and gladdened by her delight congratulating her, "Wow, Joy, you are so brave to be doing all that hard multiplication." In an instant I took the wind out of her sails. She picked up from my statement that math was something to fear and is hard, not something to enjoy. She quickly incorporated my language and demeanor towards the sheet she had been previously relishing in. Luckily, I realized what I had done, and managed to do a quick patch job; yet I was amazed how my own incongruence could directly affect a student. It is fully evident from my own experience working with children how essential it is to possess this integration and congruence.

Rogers often uses the word “realness” to describe a congruent person. A congruent person is never playing a part. They are their real selves, and to be real they must fully know themselves. Rogers describes the realness a therapist must radiate in order to be effective:

...the therapist should be... a congruent, genuine, integrated, person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly.

Rogers writes in detail about the realness a teacher should display. He beautifully describes how a teacher should approach students:

Perhaps the most basic of these essential studies attitudes is realness and genuineness. When the facilitator is a real person, being what she is, entering into a relationship with the learner without presenting a front or a facade, she is much more likely to be effective. This means that she comes into a direct personal encounter with the learner, meeting her on a person-to-person basis. It means that she is being herself, not denying herself (1989, p. 306).

Meeting a student or child on a person-to person basis is powerful. A great deal of my success working with children is based on this idea. Although I have long been aware of Rogers, I would not necessarily have known to cite him as the reason I operate this way in my teaching. I have noticed for a long time, that I treat children of all ages differently than do most adults. I talk to them just as I would to anyone else. I listen to them just the same and respect their time and opinions. Many people seem to treat children like they are something else, like they are not people, or half people. I think it's strange that most people do this, and I have yet to meet a child who will not talk or interact with me. For the special needs child this half-person treatment

is exacerbated, not only are they half people, but they are sometimes viewed as broken or sick. Add in a fear of unpredictability, and not knowing how to “handle them,” and it becomes clear how person-less special needs children are perceived to be. It is difficult for me to not become vehement about this subject. Children are people. Those with special needs are people. Children with special needs are 100% people and deserve to be treated as such.

Research Support for Empowered Students

There is a great deal of research to support the idea that giving special needs students the power to control their education and life is a more useful philosophy than that held by traditional special education. It truly comes down to empowerment. Empowered learners learn better. Keyes and Owen-Johnson (2003) give a practical description of how IEPs have revolutionized special education by taking it from an institutionalized and pathologized practice, to a more person-centered approach. Keyes and Owen-Johnson (2003) assert that while special education has made great strides, there are many ways IEPs can be generated and followed using a stronger person-centered focus, with even greater and more positive results.

Learner-centered education reasons that if students set their own goals, they are more likely to meet them. This simple difference can change IEPs from dreaded tally-marking sessions, to a self-determined plan of goals and rewards towards which the student works. In a study of direct student involvement with IEPs, especially during planning meetings, Arndt, Konrad, and Test, *Effect of the Self-Directed IEP on Student Participation in Planning Meetings*, (2006) observed that such meetings can help special needs children gain self-determination, leadership, and problem solving skills.

Special needs students often have had much in their lives determined for them, educationally and otherwise (Algozzine et. al, 2001). Many special needs adults find healthy decision-making and life planning difficult since well meaning but misdirected special education practices have been inimical to these individuals acquiring these crucial life skills (Algozzine et. al, 2001). Recent legislation has heightened

attention to issues of self-determination, and has made teaching such skills required by law:

The self-determination movement is among the most important current issues in the fields of special education and rehabilitation today. The right to make one's own decisions about life and future is viewed as an inalienable right by American adults without disabilities, but has only recently been recognized for adults with disabilities (Algozzine et. al, 2001).

If a student has never had to make their own decisions or determine their own path, how are they to face the challenges of a life filled with decision making? In a person-centered or learning-centered environment, the learner leads. Self-determination is the rule, rather than the exception. Many educators strongly endorse a person centered approach in order to counteract this common shortcoming (Keyes & Owen-Johnson, 2003; Algozzine et. al, 2001; Thousand et. al, 1999).

Unconditional Positive Regard and Inclusive Education

The fourth condition of client-centered therapy, that “the therapist experiences unconditional positive regard for the person,” is a transformative and powerful idea. As Rogers (1989, p.225) explains, “It means there are no conditions of acceptance, no feeling of ‘I like you only if you are thus and so.’ It means a prizing of the person...” The therapeutic relationship is like no other relationship. The therapist’s job is to see and to love a full person, in order that they may fully see and love themselves. This means feeling a warmth and acceptance for both flaws and strengths; more than in the typical relationship.

Person-centered education, especially for special needs learners, expresses “... a caring for the learner, but a non-possessive caring. It is an acceptance of his other individual as a separate person, having worth in her own right. It is a basic trust -- a belief that this other person is somehow fundamentally trustworthy” (Rogers, 1989, pp.308-309). Prizing is emotionally essential in a learning-oriented relationship. It is easy for students to feel admired for academic skill,

or distanced due to lack of skill. Academic skill should not be equated with likability and goodness, especially for the special needs student. Although an incredibly complex area to navigate, it is essential for all students to feel valued by their teacher, no matter their innate or learned abilities.

In a thesis on different perspectives on empowering learners, Adams, Cooper, Johnson, and Wojtysiak (1996) found that parents, teacher, administration and students have very differing senses of a student's academic and behavioral abilities. Students typically have higher expectations of their academic abilities than their teachers, and lower expectations of their behavior than their parents. Furthermore, "...other school personnel who have frequent contact with special needs students also have low expectations for these children. They treat them as though they are less capable than they are, thus discouraging them from developing to their full potential." "Students need to buy into the importance of education and the benefits of learning. Often they may have to overcome their home situations, parental expectations and their limited abilities" (Adams et. al., 1996).

The determination of the learner can truly make all the difference; yet parents and teachers may be inadvertently holding back students by not believing in and honoring their power to be self-determining. A person-centered approach in special education could drastically change this mindset and empower students and transform the environment in which our children now learn.

Empathy and Inclusion

The fifth condition is that "The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client" (Rogers, 1989). Speaking directly to educators on the importance of empathy Rogers states:

This attitude of standing in the other's shoes, of viewing the world through the student's eyes, is almost unheard of in the classroom. One could listen to thousands of ordinary classroom interactions without

coming across one instance of clearly communicated, sensitively accurate, empathetic understanding. But it has a tremendous releasing effect when it occurs (1989, p.311 from *The Interpersonal Relationship in the Facilitation of Learning*).

Such deep empathy is vital to the special needs student. What is it like to move through your day when you have autism? Perhaps faces are overwhelming. Their eyes contain too much information, and they expect you to answer verbally when you do not understand what words represent. Even thinking for a moment what it might be like to be autistic can serve a student. Is verbal, face-to-face communication too difficult? Perhaps we can communicate with play dough, or by patting each other on the back, or making patterns with blocks. I often feel that even just simple connection is an achievement when working with nontraditional learners. Being observant enough to break through barriers and communicate is a triumph. Having empathy for a student's perspective and world is essential. In order to be able to teach anything, one must find out how they learn.

In the history of special education, there has been focus on teaching interpersonal skills in order to improve relationships with peers and family members. Empathy is being able to interact and be understanding of others. Unfortunately, there has been little taught about having healthy relationships with oneself.

Communication of UPR and Empathy Achieved and Inclusion

The sixth and final condition is "The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved" (Rogers, 1989). A client must really feel that the therapist understands and prizes them. If a therapist does not communicate understanding and warmth to the client, how then is the client to be aware of the nature of the relationship?

I think we have all come across people who seem to be good listeners, who look like they are listening intently, but when they react to what you have said it is obvious they did not truly hear you.

Conversely, most people have also had the pleasure of interacting with someone really understanding, even understanding what you cannot quite put into words. Not only is this about listening and truly understanding, but also being able to express the essence of what you heard so that the client knows you understand.

Applying the sixth condition in the teacher-student relationship involves the teacher conveying acceptance and warmth toward each learner and toward classroom contributions students make. Also it means accurately representing where a learner is, for example saying to a student, “you understand how money works, but all those silver coins look the same to you, it is really tricky.” I remember as a child being endlessly frustrated when a teacher would think they understood what I was confused about, but really they did not. Other times, students would ask a question and receive an answer that made fellow students wonder if the teacher even listened to the question.

Condition six is difficult in the educational climate because the teacher must to an extent understand how the student understands and problem solves, what modalities they favor (i.e. oral, visual, kinesthetic), and then convey this all in explaining course material and answering questions. To accomplish this takes observation, time and creativity on the part of the instructor. This individualized focus on each student in the classroom is at the heart of a learner-centered approach in the educational environment.

A thoughtful article on the ADPCA website by Barry Grant about the non-directive nature of the person-centered approach entitled *Principled and Instrumental Nondirectiveness in Person-Centered and Client-Centered Therapy* speaks to the type of being with a student described above. Grant expresses how learning should flow as a natural extension of a student’s interests and passions:

Client-centered therapy fully respects clients’ right to determine their path in life. It makes no assumptions about what people need or how they should be free. It respects clients as authors of their own lives and provides them with a space to rewrite their story, if they want to. Ibsen describes liberty as giving each individual

the right to liberate himself, each according to his personal needs (1989).

I am inclined to rephrase this last idea of “liberty as giving each individual the right to educate himself, each according to his personal needs.” Imagine how this would revolutionize the educational system: giving children the right to determine their path in education and life, as well as making no assumptions about what children need or how they should learn. This is a bit philosophical in nature, and in practical application moving our current educational system to this place would be a mighty battle.

Conclusion

Though the following quote may seem overly long, for me, it shines light on the heart of this matter: the transformative power of knowledge and learning when it is a truly person-centered approach. Grant quoted Edwards in his paper on the nondirective nature of the person-centered approach, expressing this inspiring idea:

Wittgenstein’s [notion of sound human understanding] is the expression of a religious commitment; it is the expression that is, of a fundamental and pervasive stance to all that is, a stance which treats the world as a *miracle*, as an object of love, not of will. The sound human understanding is the mark of such love, for it is a feature of love that it never literalizes any perception; love is always ready to go deeper, to see through whatever has already been seen. From the perspective of loving attention, no story is ever over; no depths are ever fully plumbed. The world and its beings are a miracle, never to be comprehended, with depths never to be exhausted. Thus the sound human understanding is essentially a religious response.... It is a response that makes sheer acknowledgement, not control, central (1989).

Although some may balk at the metaphysical tone of this passage, I found it beautiful. Learning should be miraculous and love based, students should be encouraged to chase their interests. Knowledge is endless, any subject can be explored deeper and deeper, and teachers should acknowledge and respect victories in learning, not look to control them.

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Errata:

Teaching Person-Centered Counseling Using a Co-Counseling Experience

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Following is Dr. Hess' full article, which includes material inadvertently deleted from the original publication. We apologize both to the reader and to Dr. Hess.

Abstract. *Rogarian attributes of congruence, unconditional positive regard, and empathic understanding are at the core of person-centered counseling. The author presents a training model for undergraduates based on these seminal ideals. Included are how to create an emotionally safe environment for acquiring clinical skills, the importance of developing in-class community, how to facilitate choosing co-counselors, and the impact of supervision and feedback. The use of didactic exercises, required papers and reading, co-counseling triads, discussions, relevant self-disclosure, and high student and instructor engagement promotes an interactive, inclusive, clinically challenging course. Teachers and students report high satisfaction with this classroom experience.*

Carl Rogers' person-centered therapy provides a solid theoretical and practical foundation for beginning students in counseling. Rogers believed that creating a "growth-promoting climate" rests on three primary counselor attributes: congruence (e.g. genuineness, honesty, and realness), unconditional positive regard (e.g. acceptance, caring, and respect), and accurate empathic understanding (e.g. attending, listening, and paraphrasing) (Rogers, 1983). The core of the course for undergraduate psychology majors discussed in this paper revolves around these seminal humanistic ideals.

Over the past 25 years, I have taught hundreds of graduate and undergraduate students both beginning and advanced counseling skills. Several components have been consistently reliable in creating, maintaining, and encouraging a productive and successful experiential preparation for entree into the counseling profession. They include

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creating a safe learning community that will foster personal sharing, supporting appropriate risk-taking, engaging in important in-class exercises that develop empathy and trust, experiencing outside-of-class co-counseling, relevant self-disclosure by the teacher (professional and personal), role-playing in classroom fishbowls, and lastly, ending therapeutic relationships well.

This academically, personally, and clinically challenging learning environment exposes new clinical hopefuls to the near-real-life experience that a co-counseling model can provide. Some of the rewards of facilitating such a class have been the excitement of group learning, the in-class intimacy, risk-taking, creativity, genuine caring, deep learning, great warmth and humor, and the impressiveness of the wealth of talent in the room.

Although the class is usually filled with psychology majors, students from many majors have benefited from this course. The class is limited to 24 participants to allow for an even number of triad groups. On several occasions, the number was not conducive to an even number of groupings, which has necessitated one dyad or a quartet.

The following is a description of how to teach an Introduction to Counseling course to undergraduates using a person-centered, co-counseling model. It will outline the individual aspects of course pedagogy and praxis, integral to teaching a Rogerian-based co-counseling learning experience. Students (and teachers) have reported tremendous personal benefit from the experiential learning of this class. In this growth-promoting climate, the class becomes the laboratory for developing genuineness, acceptance, caring, compassion, and empathic understanding. Throughout this paper, the importance of these humanistic tenets and person-centered co-counseling practices will be demonstrated as a viable and effective model for teaching beginning counselors.

Creating a Container

Sonoma State students look forward to taking Introduction to Counseling. For decades it has had a reputation as an important class. A screening interview is used to inform the student of the class

workload (reading and writing assignments and eight weeks of taped, outside-class, co-counseling sessions), as well as the responsibilities of confidentiality and descriptions of the in-class role-plays and exercises. In addition, this interview screens out students who are inappropriate for the class because they lack prerequisites, have ongoing stressors and are in need of professional counseling, have work schedules that do not accommodate co-counseling times, or have other concerns that would compromise their learning or the learning group overall. The excitement of a hands-on learning experience with a like-minded community ignites the commitment of the group before the class begins. Strong ground rules explained in the syllabus aid in the development of security and safety students need to engage in a self-revealing learning environment.

It has been my experience that person-centered counseling taught in a student-centered classroom contributes to significant personal and clinical learning. I echo Rogers (1983) when he said, "The significant learnings are the more personal ones--independence, self-initiated and responsible learning, release of creativity, a tendency to become more of a person" (p.129). Students often report how the class has changed their lives and helped deepen them as people. One student commented, "Knowing my co-counselor trusted me with her deepest pain changed me. I felt like I had something to offer her that mattered to her. It was an awesome experience and one that I want more of."

Clear boundaries are vital to building trust in the classroom. A safe environment is established through stressing confidentiality, personal and professional disclosure, storytelling, introductory exercises, and teacher transparency.

On the first day of class, the syllabus is explained as a contract, and those who return after the first 10-minute class break agree to the conditions of the course. Maintaining confidentiality is a major aspect of the success of this learning experience. Any violation of confidence of the co-counseling triads or of personal sharing done during group work results in being dropped from the class. In more than 20 years of teaching this course, I have asked three students to leave because of a breach in confidentiality.

My teaching style is interactive, and I use personal and professional disclosure to help create an environment of honest discovery within a nonjudgmental atmosphere. As a clinician for 25 years, I have treatment stories of every ilk. I have experienced the successes and the less-than-noble moments that come with honest, contactful interaction. Using my experience to help identify and reduce the fears that come up in this class is one way to begin initiating trust.

A good deal of energy is expended at the beginning to help students develop belief and confidence in themselves and each other. As Parker Palmer (1998) says,

I should have remembered from my own experience that students, too, are afraid: afraid of failing, of not understanding, of being drawn into issues they would rather avoid, of having their ignorance exposed or their prejudices challenged, of looking foolish in front of their friends. When my students' fears mix with mine, fear multiplies geometrically – and education is paralyzed. (p. 37)

Storytelling; congruent, in-the-moment check-ins; and humorous anecdotes from my own professional development have been effective in breaking the ice and helping to normalize fear and to avoid educational or personal paralysis.

Authentic transparency of the teacher as well as his or her availability during office hours, via e-mail, over the phone, and in the 30-minute supervision sessions with each co-counseling triad are important additional components. For a solid clinical learning community that supports and encourages self-disclosure and trust to emerge or develop, it is important for the teacher to be a role model who takes the risks she or he is asking the students to take.

Developing Community

Developing a clinical learning community is the beginning phase of the course and is the crucial foundation for the entire classroom experience. Around-the-circle check-ins, in which students

share what is currently relevant to them, bring a sense of connection from the onset of the first class. Icebreaker exercises, questions often asked by beginning counselors, issues of diversity and countertransference, and humorous anecdotes from my own clinical experience pepper the facilitated discussion of the first few classes.

The importance of warmth and humor cannot be underplayed. As Thomas Kulman mentions in *Humor and Psychotherapy* (1994), there are several beneficial psychological consequences of laughter and humor evident in studies of educational processes. Kulman has noted that studies have shown humor aids in acquisition of new information, maximization of attention, stimulation of imaginative play, and positive correlations to measures of intelligence and empathy, as well as varied measures of creative behavior. Rogers and many others endorsed humor as a cardinal trait of the fully functional human (Hickson, 1977). Humor fosters intimacy and intra/interpersonal confidence and helps the medicine of feedback and self-disclosure go down in a way that feels uplifting and inclusive.

Building community is intertwined with laying the groundwork for students' choosing their co-counselors and beginning dyads. Didactic exercises, theoretical lectures and small- and large-group discussions prepare students for becoming co-counselors. Several handouts, given during the first three weeks, examine individual behavior in groups, including when one self-discloses and how much. For example, I have used Egan's *The Skill of Self Disclosure* (1976) for years because of his direct, humanistic, and clear-cut orientation. Although more than three decades old, Egan's material remains relevant and helpful to students in group training.

Reading, writing inventories, and interpersonal in-class exercises introduce students to accurate empathy, transference awareness, confrontation, attending, aspirational and mandated ethics, listening, transparency, authenticity, compassion, and paraphrasing. Having read and practiced these skills, students are better prepared to use them in their triads. As students practice listening, attending, paraphrasing, and empathic attunement, they develop a sense of mutual respect as the group members begin to understand that they are in a shared situation. Everyone practices on each other, and each values

doing a good job. At this point of skill development, students choose each other as co-counselors.

Choosing Co-Counseling Triads

For eight weeks, students meet weekly outside of class as co-counselors with an observer and practice what they are learning in class while being audio recorded. The co-counseling experience is the fundamental aspect of the success of the course. Students put considerable attention into the triads. How the co-counselors navigate the frustrations of learning beginning counseling skills while simultaneously developing a therapeutic relationship contributes to the depth and scope of the learning in this course.

The day of choosing partners usually produces a great deal of excitement and tension. Before choosing, students have prepared their autobiographies. These are written, two-page, bullet-point outlines of their major life experiences, their personal strengths and weaknesses, and the hours they are available for counseling. These papers are shared in silence until each group member has read them all. There is a noticeable energy shift after this exchange. It is as Maureen O'Hara (2003) says, "Through intimate meetings with people struggling to find their way, we encounter the seemingly boundless capacity for learning and healing even of those who have lived through unspeakable horror" (p. 67). Learning about classmates beyond the initial exterior deepens class members' level of intimacy. Upon checking in after the readings, students often are moved to tears, feel speechless, or say they feel overwhelmed or privileged to have been entrusted with the glimpses of their peer's life. Many wish they had been more courageous in their own sharing, and several have openly committed to the group to take risks more often as the class continues.

Check-ins precede the choosing process. During this time, feelings of inferiority typically emerge for students (i.e. memories of not being chosen on the play yard for sports or for other social membership). Personal experience has shown that outwardly addressing the trepidation of the group and linking it to how clients often feel when they begin (or deliberate about beginning) treatment aids in normalizing group anxiety.

Over the years I have tried varied methods of dividing the class into co-counseling triads. Random assignment, teacher assignment, and computer-generated assignments have all been employed to create the three-person learning groups; none has been as effective as student selection.

I explain ground rules for choosing the triad and give a brief lecture supporting honest exploration when selecting persons for the co-counseling experience. Encouragement is given to find those who feel like a “good fit,” to avoid joining up with friends or grouping out of fear they won’t be chosen, to say “no” when it does not feel right, to trust themselves and take a risk to pursue the people they want, and to not be attached to the outcome. Instructions also include the suggestion that if there is a specific class member with whom they are interested in working, they need to approach that person first.

Students stand in the center of the room while interviewing each other and clustering into co-counseling triads. To signal that they are grouped and unavailable, the students sit together and begin to schedule their first co-counseling appointment. The primary purpose of the initial negotiation is to determine who will be whose counselor. After that decision is made, each student will maintain the same role for the entire eight weeks. I then instruct students to think of the triad as a professional training ground. They are asked to avoid fraternizing outside of class and to complete in-class exercises with students not in their own triad in order to protect the integrity of the co-counseling container.

A debriefing exercise to release the remaining tension from the choosing process is done. One of my favorites is for each person to stand in a circle shoulder to shoulder, then taking a half turn to the right, the person behind gives the person in front of them a shoulder rub. After one or two minutes, instructions are given to turn around and return the favor. Amid the sighs and giggles of relief, brief statements are made out loud regarding the current subjective experience of the class members. I often hear, “I’m glad that’s over,” “That was harder (or easier) than I thought,” “I didn’t like that,” or “I was surprised that people wanted me to be with them.” After a 15-minute break, students check in, each person taking time to more fully share the experience of choosing and being chosen.

At this time I explain the triad ground rules (see appendix) and answer questions, such as: “What if I am tired, should I still try to see my client?” (Yes, see your client and examine self-care and other personal issues that might arise as a result of the role.); “If I feel like my counselor is not understanding me, can I tell him?” (Experiment with taking risks to state your perceptions and experience and see what happens.). I offer the students genuine reassurance and support and remind them of my availability for consultation if need be.

Developing Counseling Skills

In addition to the outside co-counseling experience, in class students review theories and watch clinical training videos of “master” therapists, such as Carl Rogers, Fritz Perls, Albert Ellis, James Bugental, Virginia Satir, and others. Many theoretical orientations of counseling and therapy are explored, discussed, and practiced in small groups or in a written format.

To answer students’ individual and personal questions as well as to monitor their progress in overall learning, I require frequent, brief integration papers. Integration papers are short academic explorations of the course material and in-class experiences punctuated with the students’ personal insights and awareness. In a great integration paper, the student discusses the significant learning from class and the triad and elaborates the discourse with lessons from his or her own personal life.

The themes that emerge in the group through the papers then become the topic of the weekly lectures on practice. These papers also provide an opportunity for teacher and student to connect more personally and allow the teacher to address individual challenges noted in the classroom or in the writing assignments. The co-counseling experience stimulates thoughts and feelings for everyone, and these informal papers provide an arena for students to more fully explore the issues that are relevant to them.

I model open, honest relationship with my students through the integration papers, supervision, in-class lectures, and exercises. The modeling of congruence is essential to the training of effective counselors. Through the process of student reflection and the teacher’s

candid feedback, each becomes more known to the other. This honest interaction, what Sherry Kessler (1991) calls the “teaching presence,” can facilitate an experience similar to the working alliance found in counseling. When the teacher can appropriately share vulnerability and is “willing to feel deeply, to be moved or stirred by what a student expresses or by what comes up for the teacher in the presence of these students or the themes being raised” (Kessler, 1991, p. 10), trust and intimacy develop. Relationship is fundamental to all good counseling (Kottler, 2004).

In-class exercises reflect the content under examination and bring the material alive while deepening student relationships. A combination of humorous and playful assignments combined with more serious investigation into oneself and one’s family seems to work well. For example, when studying the psychoanalytic theory, the class is divided into groups of four and each person characterizes himself or herself as a color, an event, a flower, a food, and a car. Using the same categories, they then describe each other. After listening to how the others perceived them, they share what they assigned as representative of themselves. The students are instructed to share with each other the rationale for the choices made for himself or herself and for each other and to discuss the similarities and differences. During the large-group discussion afterward, students typically guess the exercise as an example of perspective and how the unconscious works. By highlighting the discrepancy between how we see ourselves and how we are seen by others, the class becomes aware of previously unknown parts of themselves. The idea that one is perceived as a red Porsche while self-identified as a station wagon allows new possibilities of self-perception to emerge and become conscious.

An important in-class exercise is co-counseling using a fishbowl format. The fishbowl experiences inspire, encourage, and support the students to take academic and clinical risks, to test individual counseling responses, and to receive feedback regarding effectiveness from their peers. I usually do the first counseling demonstration with a student volunteer as the client, following up with my own self-critique of the 15-minute example session. I then ask two students to volunteer, one as the counselor and the other as the client. The client is asked to bring up a current concern to which the counselor will give 15 minutes’

attention. The rest of the class and the instructor sit in a circle and act as a group observer for the dyad, giving feedback to the counselor as to his or her effectiveness. After the self-critique, we ask the student counselor if she or he wants peer feedback, and if so, the class then tells him or her what they saw and what questions they had. Peer feedback from the group or the individual observer in the triad helps the student counselors stay current with their learning and helps denote the areas where improvement is needed.

As the clinical focus is person-centered, most of the skills focus on genuineness, caring, and empathic understanding using attending, listening, and paraphrasing. The deeper component of the course involves how the student's intrapersonal discovery and insight interfaces with the class as a learning community and then expands out to the world as a whole. O'Hara (2003) captures it by saying,

When individuals find that their own personal and authentic expression provides some unique and vital element in the life of the group, and where there is coherence between their inner world and the community in which they live, they experience a deep sense of fulfillment and joy. (p. 73)

Students often mention the happiness that accompanies personal growth while learning to serve others. There are many comments on trying new ways to communicate with roommates, family, and friends and having success with their attempts. Group members often write about and share in their check-ins how much their co-counseling experience facilitated their learning the concepts experientially and how happy they were to have had the experience with their triad members and the class at large. It is my belief that learning counseling skills is best facilitated by practice and feedback. This feedback, along with supervision, is imperative for the beginning counselor to reflect and learn from the weekly sessions.

Providing Supervision

Five forms of clinical supervision are provided in this course: (1) the triad observer offers peer supervision, (2) the teacher provides professional supervision during the required half-hour session with each triad, (3) the class breaks into small supervision groups (not with their triad members), in which students share what they are learning in the counselor role, what they are finding most challenging, and what questions they have about counseling, and (4) the use of the audio recordings for adjunctive supervision with the instructor and for writing the final co-counseling paper. I direct students at the beginning of the semester that the counseling sessions may only occur with a recording device present. In circumstances where there is a discrepancy of memory, these tapes can be invaluable.

Finally, peer feedback in the fishbowl exercise is the fifth modality used to provide supervision. Peer feedback also facilitates an interactive, interpersonal learning experience. Self-empowerment, confidence building, improved competency, and enhanced commitment to the co-counseling process are positive results of supportive, student-centered, honest feedback from the teacher and the observer in the triad. Trust is deepened by students' attempts to understand and help each other learn and by increasing risks in self-disclosure during the fishbowl feedback, teacher supervision, and in-class supervision groups.

The exploration of meaningful feedback consists of four components: (1) curiosity and exploration of counseling responses, (2) internal dialogues that are disruptive to the counseling relationships, (3) fears of failure and success, and (4) questions about technique and process. For example, one male student was unaware that while responding to a peer in a fishbowl role-play, he kept addressing the client as "Buddy." "OK Buddy, what's going on with you?" and "Well Buddy, your girlfriend doesn't seem to like what you are doing." One student watching the interchange was angry and frustrated with her classmate because his language felt disrespectful and "one-up" to her. The client echoed some of this feeling as well. The counselor student asked the rest of the class for our perceptions. With honest feedback, deep awareness broke through for the counselor, who was then willing

to speak about his fears of being “too soft” if he outwardly showed empathy. His dad had called him a “sissy” if he ever cried or was tender toward his parents or siblings. The influence of the past on the present was profound to observe, and everyone learned something that day.

By midterm, student relations are strong, the level of intimacy in the triads is noticeable, and there is a high level of risk-taking and candid disclosure among the group. In-class check-ins and exercises, supervision groups, and fishbowls support safety and trust among the members and with the teacher. Feeling encouraged and confident, students are more congruent, compassionate, immediate and patient with one another in their observing and counseling. They are “lifted beyond their own personal best” (O’Hara, 2003, p. 66) through their co-counseling experience individually and the class overall.

Experiencing Closure

The last crucial component in the course is the group closure exercise. We devote the last two classes to each student’s taking center stage and being recognized by their classmates and instructor. One at a time, each student receives positive feedback regarding aspects of himself or herself that their peers have noted and appreciated. While receiving feedback, the student is instructed not to speak and to only say “thank you” at the end. Students report enjoying the experience of both giving and receiving acknowledgment, and many are moved by the comments of their peers. The exercise is an upbeat ending to the class each semester, and students feel touched and appreciated.

Conclusion

Challenging students to grow and learn through exercises, written assignments, classroom fishbowls, and co-counseling experience is a rewarding pedagogical pursuit. Creating a classroom container by building trust and establishing clear boundaries helps develop community and provide a strong foundation for a meaningful, interactive learning experience. The co-counseling sessions, along with various modes of supervision and support, provide students with an

immediate opportunity to practice congruence, authenticity, and genuine positive regard with other like-minded individuals.

By the end of the course, students have a strong sense about whether the field of counseling is something they wish to pursue further with advanced education or training. They also have a direct experience of the beginning skills of attending, listening, paraphrasing, and authentic self-disclosure. Person-centered counseling taught in a growth-promoting climate stimulates the students' release of creativity and genuine caring about others. In addition, it facilitates students' taking interpersonal risks and helps develop trust and mutual respect. All of this promotes psychological and academic growth, encouraging students to develop further those attributes learned in class and supporting emerging humanistic counselors.

Training students in this interactive and dynamic way makes for a rich teaching experience. As an instructor, I have appreciated the teachers my students become as they deepen and are more visible through this joined learning opportunity. Blending study and practice becomes a foundational influence for continued success in all aspects of our students' lives.

Lastly, I hope what students learn in my classroom supports them to be the best parents, teachers, politicians, doctors, persons, lawyers, therapists, and global participants in an ever-changing world that they can possibly be. It is my belief that a rigorous, grounded, holistic education can impact people to pursue and actualize their greatest potential. Fundamentally, it is to that end that I do what I do, in and out of the classroom.

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Appendix: Co-Counseling Triad Ground Rules

1. Do not do all three weekly sessions back-to-back.
2. All co-counseling sessions are to be kept confidential.
3. Every session is to be audio-recorded. Please check that you have batteries and tape before your client arrives. If you have no recorder you must reschedule your session.
4. All audio recording is to be treated as an extension of your sessions. Make sure the tapes are identified in a way to keep the client's identity anonymous, and keep the tapes in a safe place to assure confidentiality at all times.
5. The students are to keep the same roles with the same persons throughout the entire semester, i.e.; you are always the same person's counselor, the same person's client, and observer.
6. To develop continuity, make all efforts to meet at the same time, the same day of the week, in the same place on campus. Do not meet at people's homes, outdoors, in a public place, or a place that might be interrupted. The library has rooms you can reserve weekly that work well for your sessions. Make reservations in advance and bring a timepiece.
7. Counseling sessions are fifty minutes long.
8. If one person of the triad cannot meet, the session must be cancelled and rescheduled.
9. No socializing or small talk outside of co-counseling sessions, or class, during the eight weeks of co-counseling. Email is to be used to reschedule an appointment only. Any communication outside of your sessions must include all members of the triad. Keep your therapeutic container as solid as you can.
10. Avoid collusion; do not break rules in an effort to be friendly.
11. Don't sit next to triad members or participate with them in classroom exercises.
12. Taking notes after each session in every role will make writing your co-counseling paper easier.
13. The observer is there for the counselor; avoid making comments on the client's process or content.
14. The counselor has the right to solicit or refuse feedback from the observer. The client remains in the room during the feedback, but does not participate in giving it.
15. As the observer focus on the counselor and the verbal and non-verbal interplay between the counselor and the client. Try to be out of the direct line of sight of the other two triad members. You are not to be a distraction to the co-counseling.
16. You can always talk about your triad goings-on with your counselor. No matter what role you need to address, the triad is a good place to process your experience of any of the roles.

17. Remember this is a learning experience. There is no expectation that you “should know” what to do. Everyone is in the same boat. You are all practicing on one another. Treat each other the way you’d like to be treated and you are half way there.

18. No fancy footwork. There is a fine line between taking risks and breaking out of counseling form. I expect you will practice listening, attending, paraphrasing, and begin to develop accurate empathy. You will not be trained to do counseling at the end of this semester, but you will have a “taste” of the counseling experience.

19. I am available to you for any reason. Do not hesitate to see me personally, or with your triad if problems or questions arise. There is no need to suffer silently. The teaching assistant and myself are here to help in any way we can.

IN MEMORIAM: NAT RASKIN

Nat Raskin was a quiet giant in client-centered therapy and the person-centered approach. Nat was only sixteen years old when he first encountered Carl Rogers. He was a student, a colleague, and a therapist of Rogers over his long affiliation with Carl.

Nat was a quiet but major contributor to the theory and practice of the approach. One of his succinct statements about the “new” therapy was written in 1946 and quoted in Rogers’ 1951 book, “Client-Centered Therapy”. It has become a classic statement that ought to be periodically reviewed by all who might be interested in “Person-Centered Therapy”. Nat summed up the following about the “nondirective” level of response of the counselor/therapist:

There is [another] level of nondirective counselor response which to the writer represents *the* nondirective attitude. In a sense, it is a goal rather than one which is actually practiced by counselors. But, in the experience of some, it is a highly attainable goal, which ... changes the nature of the counseling process in a radical way. At this level, counselor participation becomes an active experiencing with the client of the feelings to which he gives expression, the counselor makes a maximum effort to get under the skin of the person with whom he is communicating, he tries to get *within* and to live the attitudes expressed instead of observing them, to catch every nuance of their changing nature; in a word, to absorb himself completely in the attitudes of the other. -And in struggling to do this, there is simply no room for any other type of counselor activity or attitude; if he is attempting to live the attitudes of the other, he cannot be diagnosing them, he cannot be thinking of making the process go faster. Because he is another, and not the client, the understanding is not spontaneous but must be acquired, and this through the most intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention. (Rogers, 1951, p. 29).

Nat was a scholar, a celebrated Professor at Northwestern University and a notable researcher. In the activities of conventional psychology, he managed to hold his sensitive and sincere “person-centeredness” to those with whom he interacted as well as with his clients.

I met Nat at the first meeting of the Association for The Development of the Person-Centered Approach in 1986. We were leaving the meeting, waiting for the shuttle bus when Barbara Temaner Brodley suggested that someone should start an on-going workshop for those interested in the person-centered approach. I said that I would check a “magical place” for the site, the Roosevelt Rehabilitation Center in Warm Springs, GA. This was the site of the Little White House where Franklin D. Roosevelt administered the country for half of each year. Nat said in his characteristic way: “Great”, and along with Fred Zimring and Dave Spahn, the five of us started the Warm Springs Person-Centered Workshop. Students at the University of Georgia did much of the preparatory work. The five of us were the initial designated facilitators but dropped the idea of designated facilitators after the first workshop. Nat originally suggested that we simply did not need to discriminate between staff and participants. I don’t remember Nat missing any of the workshops until illness kept him from the 20th meeting. He stated several times that Warm Springs was his favorite workshop where he felt most free to be a person. He and his long time colleagues, Armin Klein and Jerry Bauman, were affectionately referred to as the three Amigos during workshops. It was during the first workshop in 1987 that Nat identified a difference between Rogers’ Person-Centered Theory and other tributaries from the theory of Client-Centered Theory. He succinctly stated this difference as that of systematic/unsystematic activities. He elaborated in a Renaissance newsletter that read in part as follows:

The (client-centered) therapist may go further and, in a spontaneous and non-systematic way offer reactions, suggestions, and questions, try to help the client experience feelings, share aspects of her or his own life,

etc. while maintaining a basic and continuing respect for the client as architect of the process. (v. 5, 3 & 4, 1988)

He continued:

The difference is that these (other) practitioners have a preconditioned notion of how they wish to change the client and work in a systematic fashion, in contrast to the person-centered therapist who starts out being open and remains open to an emerging process orchestrated by the client. (v. 5, 3 & 4, 1988)

Nat's personhood and presence was obvious in several organizations including the Association for the Development of the Person-Centered Approach (ADPCA). I feel fortunate to be co-authored with him in the statement of the history of this organization for the ADPCA website just a few months ago. Nat's presence was facilitative to many. I am convinced that his memory and contributions will continue to be facilitative to many more as well as to me.

Jerold D. Bozarth
April 6, 2010

IN MEMORIAM: GARRY PROUTY

Ten years ago, my mentor handed me an article about a lecture he had recently attended. The lecture was by Doctor Garry Prouty on the subject of “Pre-Therapy,” and my mentor felt that Doctor Prouty’s work would interest me, given my lifelong passion for the psychotherapy of schizophrenia and related psychotic experiences. To say that I was interested in Doctor Prouty’s work would have been – and remains – something of a colossal understatement. Pre-Therapy changed my life, and my work, from the moment my mentor placed the article in my hands.

I read about how Doctor Prouty had worked for decades in a non-directive tradition with psychotic experience. I read that Doctor Prouty valued so-called hallucinatory and delusional experiences and validated the expression of such experiences equivocally with other, more pedestrian, types of human expression. I read that Doctor Prouty could work therapeutically with individuals who did not express themselves verbally, or in common colloquial ways. I determined at that moment to meet Doctor Prouty in person.

I should say something about the way in which reading about Pre-Therapy felt like something of a homecoming for me. There was nothing in the description of Doctor Prouty’s work which felt unfamiliar or revolutionary in any theoretical sense. Rather, the approach of suspending judgment, interpretation, and differential valuing underlying Pre-Therapy made immediate, intuitive, and pragmatic sense to me from my first acquaintance.

My mentor was kind enough to telephone Doctor Prouty and make a recommendation on my behalf, and I attended in person his next scheduled lecture in Chicago. I was a nervous wreck before meeting Doctor Prouty in person – I can only liken it to the feeling of meeting a rock star or a favorite celebrity: I did get his autograph, along with an agreement that Doctor Prouty would supervise my clinical work in exchange for my assistance in translating his English-language work into German. In my shiny new copy of *Theoretical Evolutions* he wrote: “Your intelligence and compassion make us colleagues,” which was the highest compliment he could give me at the time.

I began a clinical placement at a local state-operated mental health care facility. Twice a week I made the hundred-mile round trip to the state hospital, meeting with five individuals with schizophrenia on a long-term residential unit. Once a week I made another hundred-mile round trip in the opposite direction to sit – literally – at Doctor Prouty’s feet, and process my experiences in Pre-Therapy. The technical training itself was entirely my own – I memorized the nuts and bolts of all the ways in which one might typically respond in Pre-Therapy, and practiced by myself. Many times Doctor Prouty would comment that I “knew” the approach better than he himself, and this was likely true from a technical perspective – Doctor Prouty was a thinker, not a do-er. At some point during my clinical tenure, Doctor Prouty and his wife gifted me with the first-ever certification of an American as a Pre-Therapy trainer.

Thanks to Doctor Prouty, several novice American practitioners were able to attend the International Pre-Therapy Symposium in Belgium in 2001. We were invited to present our work, some of which was published in the *International Pre-Therapy Review*, and were generally warmly received. Following my tenure at Chicago-Read, I was able to continue to practice Pre-Therapy within the person-centered approach at the Chicago-Counseling and Psychotherapy Center while accruing hours toward my LCPC licensure. The Pre-Therapy Institute was even generous enough to sponsor my licensure cost, and I continue to promote Pre-Therapy today through academic workshops at Benedictine University, The Chicago School of Professional Psychology, and Argosy University. In the Summer of 2009, Argosy offered its first-ever credit-course in Pre-Therapy at the graduate level, which many students cited as the “best course” they had ever taken. Pre-Therapy continues to be taught at The New Center and The Carl Rogers Institute as part of their didactic group supervision rotation.

In 2008 it was suggested that I assume leadership of the Pre-Therapy Institute itself. Despite a landfall of international interest in membership, the transition did not go well, and caused many personal and professional misunderstandings between the Proutys and myself, which spread wider ripples of dissent within the American Pre-Therapy community. The Institute was ultimately returned to the

control of Doctor Prouty's estate, and remains professionally dormant. However, Pre-Therapy continues to flourish in Western Europe, and we American practitioners continue to believe in, and promote, the approach as an ethical approach to the problem of providing non-directive understanding to under-resourced clinical populations.

I feel grateful to have had the opportunity to work under Doctor Prouty's tutelage, and to be encouraged in my own intuitive work by someone who could truly appreciate its value and my own motivations. Many gifted Americans work with Pre-Therapy in the Mid-West today – Leslie Spencer, Heather Parris, Jim Doherty, Susan Pauna are only a few, and excellent work on Pre-Therapy by Korey McWilliams and Margaret Warner can be accessed by students who are eager to expand their understanding of the approach.

-Amanda R.E. Aller Lowe, LCPC
Aurora, IL

I was formally introduced to the theory and practice of Pre-Therapy while attending Benedictine University's Master's in Counseling Psychology with Amanda Lowe. I was working full-time as a group home manager and was overseeing a varied group of clients in this transitional living situation. I felt drawn to understanding and being able to communicate with my clients in their most "symptomatic" states, and felt that this was a very misunderstood and often underserved population. Dr. Prouty's work was inspiring and gave me hope that through the use of empathic reflections, I could connect with my clients no matter what they were experiencing. Although the agency I worked for had very compassionate staff and the clients were well cared for, they operated under a medical model of treatment. If some of the more chronic clients would have a relapse of psychotic symptoms, they would immediately be hospitalized and/or have their medications adjusted as this was seen as the only option. Pre-Therapy offered another, more humane (in my opinion) solution to this situation. For my internship I worked at another of the agency's group homes, offering therapy to the clients for whom this normally would not have been an option, in Carl Rogers' definition of

“psychological contact.” I felt that Dr. Prouty’s definition and theory of Pre-Therapy addressed this first condition of CCT, and offered a feasible solution. I was excited by the communication I was able to have with these clients, and became involved in assisting Amanda in giving presentations and training on Pre-Therapy at Benedictine University, and years later, the New Center. When Dr. Prouty was invited to give a presentation at Benedictine University in 2001, I jumped at the chance to meet him and had him autograph the program I designed to advertise this presentation. I was filled with admiration and respect for Dr. Prouty and this revolutionary and yet somehow obvious solution to the dilemma of psychological contact. Sitting at a table with Dr. Prouty and Dr. Shukin and discussing our work was a transforming moment in my career.

In 2008 when Amanda was approached by Jill and Dr. Garry Prouty to assume leadership in the Pre-Therapy Institute, I joined and attended quarterly meetings to assist in this process. I was working on certification as a Pre-Therapy trainer at the time of Dr. Prouty’s passing, and feel his death as a loss on several levels. One of my regrets is that I was not able to visit him and Jill a few weeks before his death and did not get a chance to pay my respects.

I currently supervise an outpatient mental health clinic and provide therapy to about 30 clients, many of whom are diagnosed with schizophrenia. Pre-Therapy continues to be one of the most important skills I can offer any of my clients to avoid hospitalization and unnecessary medications. My personal goal is to be able to train each of the staff within the agency on the basic theories of Pre-Therapy in order to be able to facilitate ongoing psychological contact and empathic understanding.

-Leslie Harris Spencer, LPC
Milwaukee, WI

IN MEMORIAM: LEWIS GOVER

Lewis Gover passed away in 2009 soon before the 24th Annual ADPCA in Kutztown. I am fortunate to have worked closely for two years with Lew, on his and Ruth Sanford's *Experiencing Diversity* program beginning in 1994. Lew had a passionate commitment for Experiencing Diversity workshops, which he developed with Ruth, Ed Bodfish; Chuck Stewart; Sarton Weinraub, and others, for more than a decade. Throughout the early 2000s, Lew brought *Experiencing Diversity* to the person-centered workshops of the Eastern Psychological Association, which I; then Neil Watson; then Sharon Myers coordinated. For six years, Lew helped bring PC practice to cities across the mid-Atlantic and Northeast U.S., joining Ray Adomaitis and Ned Gaylin in Washington, DC; John Shlien and Carol Wolter-Gustafson in Providence, RI; Jerold Bozarth in Baltimore, MD; Garry Prouty in Washington, DC; and many others there and in Boston and Philadelphia. Lew was an extraordinary person. He was a beacon of strength in the PC community. He was a giver of profound and sustained trust in self actualization. Lew was a precious gift to the challenging pursuit of genuine, unconditional love.

Jo Cohen Hamilton, 2010

Ede and Lew

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