Introducing person-centred counselling

This book is about the Person-Centred Approach (PCA) to counselling. It is for counsellors, therapists, and clinical psychologists either practising or in training, and for people who use counselling skills as part of their work, but who do not want to be full-time counsellors — nurses, teachers, social workers, personnel managers, and community workers, for example. It is based on the work of Carl Rogers (1902–1987), one of the leading counselling psychologists of the twentieth century, who was responsible for some of the most original research work ever undertaken into the factors that facilitate personal and social change (see, for example, Rogers, 1957a, 1959). Throughout a career that spanned more than fifty years as a writer, researcher, and practitioner, Rogers developed and refined an approach to counselling that is widely recognised as one of the most creative and effective ways of helping people in need.

Although this book is focused on person-centred counselling, I see it as useful for people exploring a range of different approaches before committing themselves to one in particular, and a valuable resource for counselling trainers, whether person-centred or not. It offers ideas and perspectives, perhaps even inspiration occasionally, and makes reference to some of the literature, both classical and recent.

I have tried to be careful about giving the sources for the material in this book, and I am indebted to the many authors I have referred to in writing it. The hundreds, perhaps thousands of hours spent discussing the person-centred approach to counselling with students and others, talking with practitioners and being with clients, have contributed to the content of this book.

The best-known books about the PCA were written by Carl Rogers, and perhaps the most familiar of these are On Becoming a Person (1961), and A Way of Being (1980), though the book Client-Centered Therapy (1951) is probably Rogers’ most systematic presentation of theory and applications. In recent years, more books about the PCA have appeared in Britain and elsewhere that testify to the continuing evolution of person-centred theory and practice. The final chapter of this book lists and discusses some of the work that has appeared during the last ten years,
and directs you to some websites and organisations that are useful for further inquiry into the PCA.

Many books on counselling are good at describing a particular theory, and often give case-studies and examples of how counselling works in real life. However, it is hard to find books that help develop the attitudes, values and qualities that effective person-centred counsellors need. *Exercises in Helping Skills* (Egan, 1990) operates from a different theoretical base from the PCA and the same is true of *The Theory and Practice of Counselling* (Nelson-Jones, 1995). *First Steps in Counselling, Third Edition* (Sanders, 2002) takes a broader view than I do here, identifying common themes, skills and qualities for counselling generally, though its main inspiration is clearly person-centred. The present book concentrates more or less exclusively on person-centred counselling, but it is not an instruction manual for counsellors who have no other training or experience in counselling. In other words, I do not pretend that reading this book (or any book) will turn you into a counsellor.

**About Carl Rogers**

Person-centred counselling was developed by Carl Rogers, an American psychologist and counsellor, who died in 1987, aged 85. He was one of the founders of humanistic psychology, and his influence and ideas have now spread around the world.

Carl Rogers is such an important figure in the development of counselling, that it will help to know a little more about him because his life and work were so tied together. More discussion can be found in Brian Thorne's biography of Rogers (Thorne, 1992), and the new book *Carl Rogers the Quiet Revolutionary* (Rogers and Russell, 2002), so only a brief sketch is given here.

Born in 1902 in Oak Park, near Chicago, Rogers first started working as a psychologist in New York, with the Society for the Prevention of Cruelty to Children. After a while, he became disenchanted with mainstream psychology, with its emphasis on testing and treatment, and began to develop his own theories and ways of working with clients. He disliked the way psychology, at that time, seemed to treat people as objects for study rather than as individuals deserving of understanding and respect.

Rogers' own emphasis and distinctive 'non-directive counselling' became visible with the publication of his book, *Counseling and Psychotherapy: Newer Concepts in Practice* (Rogers, 1942) after receiving his Doctorate at Columbia University. By the early 1950s, non-directive counselling became known as 'client-centred therapy', particularly after the publication of *Client-Centered Therapy: Its Current Practice, Implications and Theory* (Rogers, 1951).

Later, the term 'Person-Centred Approach' was adopted when it was shown that the theory and philosophy of counselling could be transferred to other settings where people's growth and development were of central importance — in education, for example (Rogers, 1983; Merry, 1995; Barrett-Lennard, 1998).
In the 1940s and 1950s Rogers revolutionised the study of counselling and psychotherapy by making sound recordings of counselling interviews (not easy in those days), and trying to identify the significant factors contributing to successful outcomes. His book, Counseling and Psychotherapy: Newer Concepts in Practice (1942), contained the first ever transcript of a full therapy session. From these and other observations, he developed a theory of counselling and personal change that could be tested through further research and clinical experience.

Rogers devoted the last few years of his life mainly to writing and to peace work, for which he was nominated for the Nobel Peace Prize in 1987. He also ran workshops, gave demonstrations, and contributed to seminars in countries all round the world, including Poland, Hungary, England, South Africa, Ireland, South America and the then Soviet Union.

Cain (1990) has provided a summary of seven ways in which Rogers and his colleagues influenced the development of counselling and psychotherapy:

- Emphasising the central role and importance of the counselling relationship itself as a significant factor in promoting change.
- Describing 'the person' as resourceful and tending towards actualisation of potential.
- Emphasising and developing the central role of listening and empathy in counselling and other relationships.
- Using the term 'client' rather than 'patient' to signify respect for the person coming for help and to acknowledge his or her dignity.
- Making sound recordings of counselling interviews for the first time and using them to learn about the counselling process.
- Engaging in scientific research and encouraging others to do so.
- Making the counselling process more democratic and encouraging non-psychologists and non-medical people to become counsellors.

Rogers was not alone in his development of the person-centred approach: many people contributed to its formation and evolution, and others made significant contributions in the years following the pioneering work of Rogers and his students and colleagues. Though there are arguments about the extent to which some other workers have departed from Rogers' original philosophy, Gendlin's work on 'focusing' (e.g. Gendlin, 1981, 1984) is worthy of mention here, as is Natalie Rogers and her colleagues' development of Person-Centred Expressive Therapy, where clients are encouraged to express themselves through dance, music, painting, writing and drawing, etc. (see, for example, N. Rogers, 1993; Merry, 1997).

Julius Seeman's work on personality integration (Seeman, 1983) spanned several decades and provided much empirical research support for some of the central concepts in the PCA, and John Shlien's discussion, A Countertheory of Transference (Shlien, 1984, reprinted in Cain, 2002) demonstrates the novel and revolutionary nature of the PCA. Barrett-Lennard's 1998 book documents the many influential theorists who contributed to the evolution of the PCA in America and elsewhere from
the pre-war era to the present day, and the book itself carries this evolution further. Garry Prouty’s development of ‘Pre-Therapy’ is a particularly important application of the principles of the PCA to working with seriously disturbed and uncommunicative clients. (See, for example, Prouty, 1994, and my brief discussion in chapter 5.) Recently, Ned Gaylin has shown how the principles of the PCA can be employed in family therapy (Gaylin, 2001) and Margaret Warner (2000, 2001), in the USA, has been developing her approach to working with very seriously disturbed clients. Marlis Pörtner (2000) has described how the PCA can be used in caring for people with special needs, Leslie McCulloch (2002) has discussed the PCA in relation to work with ‘antisocial personality disorder’, and Elisabeth Zinschitz has shown how the PCA can be used with people with learning disabilities (e.g. Zinschitz, 2002).

David Mearns and Brian Thorne (e.g. 2000), both separately and together, have made enormous contributions to the development of person-centred counselling in the UK, as have others too numerous to mention here. While I am aware that the approach to person-centred counselling discussed in this book is of the fairly traditional kind, I have incorporated some recent developments in both theory and practice. Not to do so would run the risk of presenting the PCA as if it had somehow reached its final evolutionary stage on the day of Carl Rogers’ death. This is very far from the case, even though it is Rogers and his work that provide the main inspiration for this book. The important developments that have emerged in person-centred theory and practice during the last decades find their place within the pages of this book. I hope that readers will appreciate the liveliness and creativity inherent within the PCA, and understand how it has kept abreast of, and in many ways anticipated, developments and new directions within the counselling field.

Counselling and the Person-Centred Approach

Person-centred counselling is also known as client-centred counselling, and more generally as the Person-Centred Approach, and this can lead to some confusion. I take the term Person-Centred Approach (PCA) to refer to a particular set of attitudes and values, and a philosophy that can be applied to any setting where people’s personal growth and development is of concern.

An ‘approach’ is not a formal theory or a method, or a hypothesis to test in research. An approach, in this case, is a way of being in situations that is based on certain attitudes and values. The application of person-centred values and attitudes to counselling is generally known as ‘client-centred’ or ‘person-centred’ counselling, which does have a theory of personality and change and has been subject to a good deal of research. It is the application of a set of values and attitudes known as the PCA to a specific situation (counselling) that this book is all about.

In this book I present person-centred counselling in its traditional or mainstream form, which means I believe person-centred counselling
to be, of itself, an effective means of promoting personal change, and one
which has a specific theoretical base and discipline of its own. I have also
included some of the most influential of the new developments in theory
and practice that have emerged during the last decade or so.

**Is it counselling or psychotherapy?**

There are many points of view about the differences, if any, between
psychotherapy and counselling. I use the term ‘person-centred
counselling’ or ‘client-centred counselling’, but I could just as easily have
used ‘person-centred therapy’. Rogers did not distinguish between
counselling and psychotherapy and the distinction between them, if there
is one, is very difficult to make with any real precision.

At one time, counselling was thought of as short term, and
psychotherapy as long term, but now there is increasing interest in brief
psychotherapy, and counsellors often work with clients for 50 or 60 sessions
or more, so the distinction is becoming increasingly blurred.

Another distinction is that counselling is believed to be concerned with
identifiable problems, and psychotherapy with more profound psychological
disturbance. But more and more counsellors are finding that they cannot
confine themselves to working only with identifiable problems, which may
represent only the surface layers of much more deep-seated issues.

Finally, it is thought by some that counsellors and psychotherapists
have different training requirements. Psychotherapists have long periods
of intensive training, which usually includes their own therapy or analysis.
Counsellors, on the other hand, have much shorter training, and are not
necessarily required to undergo their own counselling.

There was some truth in this, but the picture has changed a lot in
recent years. Most training institutes in person-centred counselling offer
training periods of three or four years of part-time study. If they do not
actually require their students to be in personal counselling as part of the
training process, they do advise them to enter personal counselling before
starting to see clients themselves. The British Association for Counselling
and Psychotherapy (BACP) requires people to have had experience of being
in the client role in ways that are appropriate to their model of counselling,
when they apply for Accreditation.

The term ‘counselling’ or ‘psychotherapy’ is often determined by the
work context, rather than by any inherent difference between the two. What
is important is that person-centred relationships with clients require the
deepest commitment to understanding the unique individuality of the
people with whom we work. This holds true whether we call what we do
counselling or psychotherapy.

**The social context of counselling**

There are two areas I consider briefly here. The first is concerned with the
current professional context of counselling, and the second, broader area
is concerned with the wider political and cultural context in which counselling takes place.

The professional context
Counselling has evolved, during the last thirty years or so, into an identifiable profession with its own organisations, academic journals and codes of conduct and ethical practice. In Britain, the BACP has developed an ethical framework for good practice in counselling and psychotherapy and an accreditation procedure through which people may apply for professional recognition of their training, experience and competence. To be accredited, people have to show they have had appropriate training and experience of working with clients under supervision, and they also must agree to abide by the BACP statement of ethics for counselling and psychotherapy.

At present, accreditation is voluntary, and accredited counsellors need to maintain their commitment to ongoing personal and professional development, and are expected to have an appropriate level of clinical supervision of their work. Accredited counsellors can apply to join the United Kingdom Register of Counsellors as Registered Independent Counsellors, again a voluntary scheme, though some form of statutory registration is likely in the future.

The BACP also has an accreditation procedure for courses in counselling. To be accredited, a course has to be substantial in terms of time and content, and must meet a number of exacting criteria. If you have successfully completed a BACP Accredited course, it is assumed that the training requirement for individual accreditation has been met, but you would still have to complete 450 hours of supervised practice over three years before accreditation could be given.

There is now a separate body — the UK Council for Psychotherapy, whose aim is to establish professional standards for training and qualifications in psychotherapy. Membership of this council includes representatives from the majority of training organisations in psychotherapy, and representatives of allied professions like the Royal College of Psychiatry, the British Psychological Society, and the British Association of Social Workers.

Recent developments among person-centred practitioners towards greater organisation include the formation of the British Association for the Person-Centred Approach (BAPCA) in 1989, which now has over 1000 members. Moves towards the foundation of an international association for the PCA are complete, and a new international journal will be published by December 2002. In the USA, the major organisation is the Association for the Development of the Person-Centered Approach (ADPCA), and both ADPCA and BAPCA have developed their own journals. You will find more information about both these organisations and others in the Resources section of this book.

The increasingly organised and regulated manner of the counselling profession brings with it some advantages, but also serious concerns for
some practitioners. Arguments for increased regulation and control are usually couched in terms of protection for the public against bad, incompetent or exploitative practice. Agreed standards and criteria for training, for example, are designed to ensure that all counsellors achieve a basic level of competency, and are thus less likely, wittingly or otherwise, to do damage to people who are already vulnerable. The requirements of accrediting organisations include the demand that practising counsellors receive continuing clinical supervision. Codes of ethics and practice serve to reassure the public that the profession is monitored and bad behaviour sanctioned.

Sceptics of ‘professionalisation’, however, argue that regulation is a covert but outwardly respectable means of self-promotion, and limits the opportunities for many unqualified but otherwise competent people to offer psychological help to people in distress. They argue that there is a difference between professionalisation (which is about the protection of interest groups and the exclusion of ‘outsiders’), and professionalism (which is about skill, integrity and good practice). The case against currently proposed forms of registration for psychotherapists was made persuasively by, for example, Richard Mowbray in 1995 (see also Mowbray, 1997).

Regulations for accreditation of individual practitioners emphasise the establishment of baseline standards, but they bring with them increased bureaucracy and expense that do nothing to promote good practice. The current mood for cost-effectiveness, evidence-based practice and standardisation of treatments is leading to the setting of spurious objectives and the mechanisation of counselling into a series of skills that can be objectively evaluated. Creativity, inventiveness and experimentation become less likely in an atmosphere dogged by a complaints culture, in which professional organisations are keen to be seen as protecting the assumed public interest, rather than encouraging the active development of counselling, which is not a risk-free undertaking. This is not, however, an argument for the irresponsible experimentation by maverick practitioners at the expense of vulnerable or anxious clients. It is questionable in any case how much real protection is afforded to the public by the increasing regulation of practice. Other, older professions such as medicine and law have been subject to stringent control and regulation for many years, but incompetence and exploitation continue to exist.

Andy Rogers (2001), questions the promotion of counselling as a profession akin to the medical profession and argues that this ‘medicalisation’ ‘... does my work a disservice because it fails to acknowledge the uncertain, unscientific and existential dimensions of the encounter and the particular demands of indwelling in such territory. Paradoxically, it also talks-up counselling, dishonestly downplaying its imprecision, fallibility, and “might-work-sometimes-with-some-people” reality, and thereby misrepresenting it to clients’ (p. 76).

The standardisation of counsellor training courses (in the UK largely
under the influence of the BACP since the Courses Recognition Scheme, as it was called then, was launched in 1988), also brings advantages and disadvantages. Without much doubt, the scheme forced training providers to think carefully about what they were doing, raise standards of delivery, and provide value for money for their students. Sceptics, however, pointed to the extra cost (passed on to students) that entering into the scheme incurred, the insistence on the teaching of a core model (not a universally admired principle — see, for example, Feltham, 1997b), and the mechanistic way that courses and their students were forced into counting up hours and minutes spent in theory sessions and skills training workshops in order to satisfy the BACP’s stringent criteria. Some perfectly adequate courses which, for good reasons did not want to enter the scheme, suffered in reputation and popularity without any real justification. Other courses were tempted to fulfil BACP criteria, not because they were persuaded of their value, but because not to do so would make them uncompetitive in a very competitive market place.

To be fair, the BACP scheme is by peer evaluation, and evaluators are drawn widely from across the membership. This allows for great variety (though not infinite variety) in the interpretation of the criteria, and the BACP is keen to allow the various theoretical approaches to counselling to be represented in the material that is taught on courses and the way in which it is delivered.

Current preoccupations of the counselling field, at least as represented in the counselling literature, are with contracts and boundaries. On the surface, the issue of contracting seems sensible and uncontroversial. There is everything to be gained from ensuring that both client and counsellor are as fully aware as possible of, for example, time commitments, venues and financial arrangements. Problems occur, however, if counsellors become so afraid of being called to account at a later date for unethical or unprofessional behaviour, that they defensively place the apparent need for agreeing a contract above the need to meet a distressed, vulnerable or anxious client with a warm, open and inviting attitude from the outset.

Issues of boundaries seem to create much concern, confusion and defensiveness, particularly among training or newly trained counsellors. It is right that counsellors should have a deep appreciation for the protected nature of the counselling encounter. Very rarely is it appropriate for counsellors to become participants in the lives of clients, over and above the profound commitment they make to accompanying their clients on their unpredictable journeys into ‘self’ during the counselling hour. However, the formalisation of boundaries into a set of injunctions that prevent spontaneous acts of human kindness, understanding and love can only serve to place barriers between a hurting human being and one who is setting out to offer the opportunity for healing through a person-to-person encounter.

Those counsellors whose personal, moral framework is shaky or underdeveloped, or who have psychological needs for intimacy or sexual contact, of which they are largely or even wholly unaware, will continue
to exist whether or not they have signed up to a stringent code of ethics. This does not, of course, imply that the counselling profession should abandon its commitment to moral and ethical practice. The general tone of the new BACP Statement of Ethics for Counselling and Psychotherapy does recognise the uncertainties and risks that are inherent characteristics of the profession, and is to be welcomed for that. Boundary issues are likely to continue to exercise the minds of practitioners, but the new Statement offers more understanding of the complexities of the counselling encounter than did its predecessor.

The cultural and political context
Counsellors do not work in isolation from the rest of the society and culture in which they live. Our society is rich in cultural differences, and is also one in which some people enjoy more power and privilege than others. Counselling can be criticised for being available more to the relatively well and economically advantaged than to the very disturbed, poor or otherwise disadvantaged.

Seeing a counsellor often involves paying fees — there is some counselling and psychotherapy available through the National Health Service, and through Employee Assistance Programmes, but it is limited — so this fact alone means that some people who need it cannot afford to pay for it. This is not an argument against counselling, but it is a reminder to would-be counsellors that they may find it difficult to work with some clients whose need may be great, but whose capacity to pay is limited or non-existent.

The social context also includes groups who have particular needs, different from those of the majority. Such groups include members of cultural or ethnic groups whose attitudes to therapy, and what they need from it, may be very different from those of the majority. It is also likely that many such groups (if not all) will have experienced prejudice or some form of discrimination, and may therefore be justifiably suspicious of what counselling has to offer if it remains a largely white, middle-class activity, (see, for example, Patel and Fatimilehin, 1999).

Although counselling certainly is not politics, it does have a political dimension that therapists need to acknowledge and, more importantly, do something about. At the very least, counsellors should be aware of the social and cultural values they hold, and be prepared to confront the racism, sexism and other ‘isms’ they have unwittingly absorbed, in an effort to free themselves of unhelpful attitudes towards people who have very different experiences and expectations from themselves.

Counsellors will be more effective if they are aware of the social backgrounds and contexts of their clients, and knowledgeable enough to see how different people bring different experiences and expectations with them into counselling sessions. Being understanding of individuals includes being sensitive to the cultural norms and values that influence different people to see things in very different ways.

However, simply knowing about different cultural characteristics does
not necessarily lead to more effective counselling practice. The idea that the culturally sensitive or culturally aware counsellor needs to develop techniques appropriate to different cultural groups is problematic. Descriptions of various groups tend to describe the average person, something that can unwittingly lead to the development of stereotypes, and assumptions about the characteristics of particular groups can lead to a self-fulfilling prophecy. If clients from certain groups are believed to share certain patterns of behaviour, preferences and values, it is likely that ‘they will be treated as if these things were true and they will respond to confirm the counsellor’s beliefs’ (Patterson, 1996).

There is a limit to the extent that any counsellor of whatever approach can change his or her behaviour to take into account the presumed preferences of people from different cultural groups without seriously compromising the theoretical basis of their counselling. This holds true whether we are talking about race and ethnicity, sexual orientation, class or gender, etc. The problem, then, is one of balancing the need to know and understand factors affecting discrimination and oppression with the need to remain consistent with one's theory and philosophy of counselling.

There are two levels to be considered here. Firstly, there is a need to know and understand something about the social, economic and political construction of the society in which we live and work. This includes some knowledge of the cultural groups and sub-groups from which our clients are drawn so that their concerns can be appreciated in terms of their cultural norms and values. In relation to this is a need for counsellors to understand the nature of prejudice and how discrimination, both overt and covert, is an everyday experience for some people.

The second level is the personal level in which counsellors themselves confront the nature of their own prejudice and stereotyping. I argue, along with Bernard and Goodyear (1992), that the starting point for this is with an examination of our own cultural norms and expectations as a first step to understanding others. Later in this book I explore some ways of developing greater awareness at both these levels.

Finally, there is a broader political dimension to the PCA that includes, but goes beyond, its application to the field of counselling and psychotherapy. The PCA encompasses not only a theory of counselling and human relationships, but also provides a radical critique of the theories and assumptions contained within modern discourse about human relationships, in the broadest sense of that term. For example, the rejection, by the PCA, of contemporary attitudes towards the assessment, diagnosis and labelling of people represents a radical departure from traditional forms of psychological treatment. The metaphor of therapist/counsellor as a companion on a journey into another’s person’s inner world, directly challenges the model of the therapist/counsellor as an expert diagnostician. The expertise of the person-centred practitioner is dedicated to gaining a deep understanding of a client’s unique experience and the meanings derived from that experience. The essentially non-directive attitude of the person-centred counsellor is built on a trust in
Introducing person-centred counselling

11

the individual’s capacity (and inherent tendency) to move further towards more constructive, pro-social and self- and other-enhancing behaviour, values and attitudes, in an environment that facilitates growth and development from within the person.

The PCA, then, is not simply an alternative model or theory of counselling. It represents a fundamentally humanistic attitude towards persons as being essentially creative in outlook and pro-social in attitude. Its ‘politics’ reside in the redefining of helping relationships away from the conventional medical model towards a more collaborative one where power is redistributed and clients are able to reclaim their capacity for their own psychological determination.

Ethical issues in counselling

People who enter counselling can be in a vulnerable and anxious state. They may recently, or in the more distant past, have had experiences that resulted in immense despair for them. In such states, people are more open to being exploited than when they are at peace with themselves, and it can be easier for them to fall prey to unscrupulous and unethical practices. These range from keeping clients dependent for longer than necessary in order to keep collecting fees, through to sexual exploitation. A counsellor can be a powerful figure in the lives of lonely or vulnerable people, and clients can develop strong feelings towards a counsellor who appears wise, and is giving them time, care and attention.

If a counsellor or therapist is a member of a professional body, he or she will be bound by a code of professional ethics, or, in the case of the BACP, the ethical framework referred to above. This framework, published in April 2002, is far more flexible than the Code of Ethics it replaced, and is indicative of how the BACP’s thinking has evolved over the years. It replaces the former rather prescriptive list of ‘do’s and don’ts’ with an altogether more thoughtful discussion of values, principles and moral qualities; it recognises that choices are often not clear-cut, and that sometimes difficult decisions need to be made that, even when taken in good faith, may have unpredictable and unwanted outcomes. The new spirit embodied in this framework is far more representative of the fluid, constantly changing dynamics of counselling relationships than the original Codes of Ethics and Practice. It openly confronts the reality that knowing the right course of action to take in a particular circumstance cannot be codified into a book of rules and regulations, but instead is guided by a set of principles and values that underlie the commitment counsellors make to provide relationships with clients based on a deep sense of personal integrity.

What person-centred counselling is not . . .

This book contains a lot of information about the theory, philosophy and practice of person-centred counselling, and it discusses some of the issues that face counsellors in their work, like supervision and ethics, for example.
It also contains some suggestions about how you can explore person-centred counselling for yourself, either alone or as part of a training group. What this book is not, as I have said before, is a manual or a set of instructions as to how to do person-centred counselling. Person-centred counselling is not a set of skills or techniques, nor is it synonymous with ‘reflection of feelings’; it is not a group of communication skills, and it does not offer a range of strategies thought to be appropriate for different groups of clients.

Person-centred counselling is only partly about feelings; it would be more accurate to say that person-centred counselling concerns itself with clients as persons, and that includes feelings, but also thoughts, experience, ideas, fantasies and other sensations.

... and what it is

Person-centred counselling is a way of being with people based on a particular theory of helping relationships which, in turn, rests on a deep respect for and trust in the individual’s capacity for growth, development and creativity. It has a set of theoretical ideas aimed at exploring the processes of human growth and development, and it has a sophisticated and developing theory of personality. Of most interest to readers of this book is its theory of counselling relationships based on the presence of a counsellor with certain personal qualities, attitudes and values. It has a firm foundation of careful research into the factors that promote change, and is one of the most influential models of counselling currently in use in Britain.

It is a democratic, non-authoritarian and non-directive approach to people that emphasises constructive human relationships as the key to the change process. The PCA, perhaps more than any other approach, requires the enduring commitment to encounter clients in a direct, person-to-person manner without providing a set of rules or an armoury of techniques and strategies that control the process. This can be a daunting task for the beginning counsellor as well as for the more experienced. In the modern, technological age there is a high premium placed on the abilities of expert practitioners of any profession to identify problems quickly and apply known, effective techniques for their speedy solution. The drift towards ‘evidence-based practice’, time-limited counselling and solution-focused therapy, finds the person-centred counsellor swimming against an increasingly powerful tide.

If person-centred counsellors do not offer techniques, strategies and interventions, what, then, do they offer? Though this is a question that I explore in the remainder of this book, it would be churlish in the extreme not to attempt some answer near the beginning. (To avoid clumsy constructions like ‘he or she’, ‘he’ here refers to people of both genders):

The counsellor attends to the whole person of his client, listening to and responding empathically to the client’s experiencing process as it is lived in the therapeutic hour. He has no goals for his client, only for himself.
Introducing person-centred counselling

He sensitively and progressively becomes familiar with his client’s frame of reference with its changing and fluid content, process and nuance. He becomes progressively more sensitive to and responsive to his client’s ongoing, idiosyncratic struggle to allow more experience into his awareness with decreasing distortion or denial, to gain meaning from that experience, to change old, outmoded meanings, and to construct, for himself, a contemporary, more realistic picture of himself both as he now is and what he may become. The counsellor, in some measure, achieves this through his active engagement with the lived and experienced world of his client, without judgement but with respect and authenticity. The counsellor extends himself towards his client as a person, and allows his client to affect him, each making a difference to the other. He neither absorbs the client’s experiencing into himself, taking ownership of it for himself, nor does he direct it. Rather, he participates in it without losing his own sense of himself as both a separate person and as someone who, however temporarily, shares in this existential moment, this hour of cooperative living. He is an alert companion and, simultaneously, an empathic and non-judgmental observer. (Adapted from Merry, 2002.)

I am aware that this answer begs a lot of questions. How does the counsellor respond empathically, and what does empathy really mean in this context? How does the counsellor achieve active engagement, and what does it mean to ‘share in this existential moment, this hour of cooperative living’? What is the process through which a client goes for it to be possible to ‘allow more experience into his awareness’, and how does this promote lasting psychological change? I hope that some answers to these and other questions appear in the pages that follow.

The evolution of person-centred counselling

It is possible to identify three phases in the development of person-centred counselling, with one phase melding into the next rather than representing a sudden change of emphasis. Raskin (1996) describes twenty historical steps in the development of the person-centred approach, but here I offer a very general evolutionary process beginning in the 1940s:

• The first phase, from about 1940 to the early 1950s, could be called the ‘non-directive’ phase. It emphasised acceptance of the client and the establishment of a non-judgmental atmosphere in which the accent was on the skills of the counsellor to promote the counselling process.

The essential non-directivity of the counselling process remains in place today, but there is more emphasis on the counsellor being present as a whole person, expressing him or herself more openly than was the case during the early development of this approach.

• The second phase, from about 1950 to the early 1960s, can be thought of as the ‘client-centred phase’. Here the emphasis was placed on
counsellor attitudes rather than skills, and on reflecting the client's feelings. Theoretical ideas of resolving discrepancies between the client's 'real' and 'ideal' self became incorporated, and the idea of the counsellor as a person involved subjectively in the counselling relationship began to take shape.

- The third phase, from the 1960s to the present, is the 'person-centred phase', which emphasises counsellor attitudes and values and relationship qualities. The counsellor's role is seen even less as skilled performance and more as an expression of the counsellor being responsively engaged with the client.

The evolution of the PCA continues, and I suspect that it may now be entering a fourth stage. Pete Sanders (2002, private communication) has labelled this as the 'client-centred and experiential counselling/psychotherapy stage'. This is based on his observation that there is now a genuine exploration of theoretical origins, commonalities and differences emerging among various therapeutic approaches that share many of the fundamental philosophical concepts that are characteristic of the PCA. These approaches, loosely called 'experiential approaches', have developed new ideas of their own that, in various degrees, depart from traditional person-centred counselling, but still share many of its philosophical roots. In a challenging article, Sanders (2000) suggests ways in which approaches that have emerged over the last thirty years or so could be included under a general person-centred umbrella so that differences and commonalities can be recognised and clarified.

### About the exercises and checklists in this book

I hope you will find this book useful as part of a training programme, or as a means of helping you discover ways in which you can become more effective in your own professional and personal relationships. The exercises and checklists are designed to help you experience what I am describing, rather than just reading about them.

The best way to approach them is to get together with a small group and work your way through them. There should always be time at the end of each exercise for general discussion and sharing of the things you have learned. Most of them can also be done on your own as a way to check what you are reading and learning about counselling.

Before you go on to the next chapter, you may like to explore what you know and think you know about person-centred counselling at the moment by working through the checklist that follows. It may be that you have heard some things about person-centred counselling, and some of them might be accurate and some not. Every form of counselling gives rise to myths, legends and misunderstandings about itself. When you have finished the book and tried some of the exercises, come back to this checklist and see if your ideas about person-centred counselling have changed.
## Checklist: True or false?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree / Don’t know / Disagree</th>
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<tbody>
<tr>
<td>Person-centred counsellors think that people are basically good.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling is OK for relatively well people, but no good for very disturbed people.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling is where you repeat what the client has said.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counsellors do whatever they feel like doing.</td>
<td>Agree / Don’t know / Disagree</td>
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<tr>
<td>Person-centred counselling does not have a theory of personality.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling cannot cope with evil or destructive people.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling is good for establishing rapport with clients, but then you need other techniques to treat them.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling cannot help people with problems like fear of confined spaces, or obsessions etc.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling is too slow, and does not go ‘deep enough’ really to help people much.</td>
<td>Agree / Don’t know / Disagree</td>
</tr>
<tr>
<td>Person-centred counselling is best used with a mixture of other techniques and methods.</td>
<td>Agree / Don’t know / Disagree</td>
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Actualisation: A Functional Concept in Client-Centered Therapy

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Abstract:
This paper reviews Carl R. Rogers' concept of the actualising tendency as an operational premise in client-centred therapy. Rogers' view of actualisation is clarified including the relationship of the concept to Rogers' speculations about the "fully functioning person." The function of the actualising concept in therapy is demonstrated by reviewing segments of a therapy session. The client-centred therapist implements the actualising tendency by creating a specific interpersonal climate during the therapy session. This climate is created by means of the therapist experiencing and communicating certain attitudes toward the client. These attitudes are identified as congruency, unconditional positive regard, and empathic understanding. Rather than intervening and thereby assuming therapeutic expertise about the client, the client- centred therapist trusts the client to move forward in a constructive direction. The constructive forward movement of the client is propelled by the sole and inherent motivation in human beings; that is, the actualising tendency.

Actualisation is a concept that has been discussed at length by many psychologists including Erich Fromm, Karen Homey, Robert White, Abraham Maslow, Andras Angyal, Kurt Goldstein, and Carl Rogers. Only in Client-Centered Therapy (also identified as Person-Centered Therapy) is the concept of actualization a practical and functional premise for the work of the therapist.

The intent of this paper is to clarify Carl R. Rogers' view of the actualising tendency as the foundation block of Client-Centered Therapy and to discuss the implications of actualisation as a pragmatic and functional concept in this therapeutic approach. Specifically, the paper (1) examines Rogers' view on actualisation and his rationale for therapy, (2) clarifies the relation between Rogers' concepts of the actualising tendency and the fully functioning person, (3) discusses the function of Rogers' concept of actualisation in the practice of psychotherapy, and (4) presents a therapy segment in order to illustrate the function of a therapist who operates with the cognitive underpinning of the actualising tendency.

The client-centred approach has generated extensive research (Lambert, Shapiro, & Bergin, 1986) and has been the most research supported model of psychotherapy (Goodyear, 1987; Patterson, 1984). However, there has been a sparcity of research on, and limited understanding of, the concept and functional implications of Rogers' actualising tendency.

ROGERS' VIEWS ON ACTUALISATION AND HIS RATIONALE FOR PSYCHOTHERAPY

One of Rogers' earliest writings on psychotherapy (Rogers, 1942) assumed the natural growth tendency as the healing factor. Later Rogers (1980) added the concept of the "formative tendency" as the broader foundation block of the person-centred approach. He referred to the formative tendency as the
directional tendency in the universe. The actualising tendency is more specifically that tendency in organisms and is the foundation block for Client-Centered Therapy. In 1942, Rogers wrote:

Therapy is not a matter of doing something to the individual, or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development. (p.29)

Rogers acknowledged that his ideas about actualisation were influenced by the work of Kun Goldstein, Maslow, Angyal and others but noted that his formulation emerged primarily from his own naturalistic observations. Only after formulating his own theory did he become aware of some of the supporting work in biology (e.g., Bertalanffy, 1960).

Rogers observed that behaviours of organisms (including individuals in therapy) move in the direction of maintaining and enhancing themselves. Emphasizing this observation he asserted the idea of the actualising tendency its involving all motivation, expansion and enhancement. The basis for all of his thinking about therapy, human development, personality and interpersonal relationships (1959) was the actualisation tendency (1963). He stated:

In client-centred therapy, the person is free to choose any directions, but actually selects positive and constructive pathways. I can only explain this in terms of a directional tendency inherent in the human organism-a tendency to grow, to develop, to realize its full potential. (Rogers, 1986a, p.127)

The rationale for client-centred therapy and the person-centred approach in interpersonal interactions rests on the actualising construct in the following ways: (1) The actualising tendency is the basic and sole motivation of persons. (2) The actualising tendency is constructively directional, aiming toward increasing differentiation and complexity and resulting in growth, development and fulfilment of potentialities. (3) The effects of this sole motivational tendency on the person's experience and behaviour can be distorted or stunted by interaction with unfavourable, inadequate or destructive environmental circumstances. (4) These distorted or stunted realizations of the person create the need for psychotherapy. (5) Client-centred therapy is an attempt to create an optimal psychological climate for the person by means of the therapist providing a special kind of relationship that involves certain attitudinal qualities of the therapist. (6) This relationship fosters the person's natural actualising tendency to function in ways that overcome the effects on his/her organism of unfavourable or destructive circumstances. (7) The result of therapy is that the person's experience and behaviour become more purely constructive and more powerfully developmental and enhancing. Using the same logic, the promotion of a person's constructive growth tendency was extended beyond psychotherapy to include any interpersonal relationship where one individual can create a climate that promotes the other individual's actualising tendency.

CHARACTERISTICS OF THE ACTUALISING TENDENCY IN ROGERS' THEORY

Rogers' construct of the actualising tendency is an organismic theory with the fundamental qualities in human nature being viewed as those of growth, process and change. In Rogers' theory, "Man is an actualising process" (Van Belle, 1980, p.70). Actualisation is the motivational construct in organismic theory and, thus, is embedded in the organismic growth process and is the motivator for change. The organism/person is the basic unit of inquiry in Rogers' thought. The principle characteristics of all organisms, including the human, have this tendency in common although Rogers' term "person" is the one used for the distinctly human realization of organismic nature.
In describing this motivational principle, the other main characteristics of organisms and those peculiar to persons are necessarily brought into view. The major properties of Rogers' "actualising tendency" construct in organisms/persons are as follows:

1. The actualising tendency is individual and universal (Rogers 1980). The expression of the tendency is always unique to the individual and also the presence of the tendency is a motivating tendency for all organisms.

2. The actualising tendency is holistic (Rogers, 1959). The organism/person is a fluid, changing gestalt with different aspects assuming figure and ground relations depending upon the momentary specific aims of the person and upon the immediate demands of the environment. The actualising tendency as the motivational force functions throughout all systems of the person. It is expressed in a variable, dynamic and fluctuating manner through the subsystems of the whole person while maintaining wholeness and organization.

3. The actualising tendency is ubiquitous and constant (Rogers, 1963; Rogers & Sanford, 1984). It is the motivation for all activity of the person, under all circumstances, favourable and unfavourable to the specific person. It functions as long as the person is alive. The moment by moment living-the moving, responding, maintaining of wholeness, feeling, thinking, striving-are all manifestations of the actualising tendency.

4. The actualising tendency is a directional process. Although it involves assimilation and differentiation activities while maintaining wholeness, the wholeness is perpetually changing. It is a tendency towards realization, fulfilment and perfection of inherent capabilities and potentialities of the individual (Rogers, 1963). It is a selective process in that it is directional and constructive. It tends to enhance and maintain the whole organism/person.

5. The actualising tendency is tension increasing (Rogers, 1959). The organism/person is not a drive reduction system but one which inherently and spontaneously increases tension levels to expand, grow and further realize inherent capabilities. The directionality of the actualising tendency requires its tension increasing characteristic.

6. The actualising tendency is a tendency toward autonomy and away from heteronomy (Rogers, 1963). The person moves inherently toward self-regulation and away from being controlled.

7. The actualising tendency is vulnerable to environmental circumstances (Rogers, 1980; Rogers & Sanford, 1984). Under unfavourable circumstances to the organism the expression of the actualising tendency may be affected such that the organism becomes distorted although the tendency remains as constructive as possible under the circumstances. Rogers (1980) uses the metaphor of the potato sprout growing towards the tiny source of light in the dark cellar to clarify his point. He said:

The conditions were unfavourable, but the potatoes would begin to sprout-pale white sprouts, so unlike the healthy green shoots they sent up when planted in the soil in the spring. But these sad, spindly sprouts would grow 2 or 3 feet in length as they reached toward the distant light of the window. The sprouts were, in their bizarre futile growth, a sort of desperate expression of the directional tendency I have been describing. They would never become plants, never mature, never fulfil their real potential. But under the most adverse circumstances, they were striving to become. Life would not give up, even if it could not flourish. (p.118)
8. The concept identified as "Self-Actualisation is a Construct referring to the actualisation tendency manifest in the "self" a sub-system that becomes differentiated within the whole person (Rogers, 1951; 1959). This construct is crucial to Rogers' theory of the development of normal personality and psychological disturbances. He theorizes that under unfavourable conditions the actualisation of the self sub-system (dictated by self-concepts) may become discrepant from and in conflict with organismic experiencing. Such conflict results in loss of the person's wholeness and integration with consequent disturbance. Alternatively, under favourable developmental circumstances, persons are theorized as remaining open to experience and as developing self-concepts which are harmonious with organismic experiencing, with the consequence that wholeness and integration of the person is fostered.

9. The concept of consciousness, in the sense of capacity for self-awareness, is viewed as a distinctive human channel of the actualising tendency (Rogers, 1980). Consciousness gives the person a greater range of choices for self-regulation and permits potentialities not present in other organisms.

10. Human beings have a social nature, consequently a basic directionality of the actualising tendency in humans is toward constructive social behaviour (Rogers, 1982). It is true of all directional characteristics of individuals and species, that the better the environmental/social conditions of the organism, the stronger the expression of the directional characteristic. Thus, in humans, the capacities of empathy, affiliation and language result in constructive social behaviour under adequate (or better than adequate) conditions. It is important to recognize that in Rogers' thinking all potentialities of individuals and of species are not aspects of the directionality of the actualising tendency (Rogers, 1989). For example, people have the potential to vomit or to commit murder. In Rogers' view, these potentials do not show expression under such favourable circumstances as the interpersonal climate of client-centred therapy.

The first seven of the above characteristics of the actualising tendency, according to Rogers, are common to organisms. The last three characteristics, points eight, nine and ten, are considered distinctive to the human organism and are crucial in his theories of personality and psychological disturbance as well as relevant to therapeutic process.

Rogers (1980), while viewing the actualisation tendency from the stance of his scientific orientation, always asserted that it is a hypothesis, "open to disproof." Nevertheless, the conception of actualisation functions in Rogers' theory as an axiom; that is, it functions as a principle that directs therapist behaviours. Specifically, the organism/person is always actualising because actualisation is the motivational concept that accounts for all living activity. In effect, the person is always actualising him/herself as best as he/she can under the circumstances. Whenever destructive or self-limiting behaviour is observed, the actualising tendency concept directs inquiry toward the circumstances that have distorted or limited constructiveness.

**THE RELATION BETWEEN ROGERS' CONCEPTS OF THE ACTUALISING TENDENCY AND THE FULLY FUNCTIONING PERSON**

Rogers' concept of the "fully functioning person" is often misunderstood as being a goal for clients in Rogers' therapy. In fact, Rogers is presenting his views on the meaning of "the good life" and clarifying the manner in which the actualising tendency functions in human beings. Rogers formulated his concept of the "fully functioning person" as well as his whole theory from the context and vantage point of his experience as a client-centred therapist The characteristics of the "fully functioning person" are an extrapolation from concrete observation of his individual clients and are based on the common
features of his clients who progressed in therapy. The common features which Rogers expressed as the "fully functioning person" are features of directional development in persons. Rogers (1961) said:

If I attempt to capture in a few words what seems to me to be true of these people (who showed positive movement in client-centred therapy), I believe it will come out something like this: The good life is a process, not a state of being. It is a direction, not a destination. It is not... a state of virtue, or contentment, or nirvana or happiness. It is not a condition in which the individual is adjusted, or fulfilled or actualised (pp. 186-187) (The italics are the authors).

In other words, the "fully functioning person" does not represent a state of being, a class of persons as in Maslow's (1970) "actualising personalities," nor a developmental level in Rogers' theory. Instead, Rogers is expressing dimensions of directionality that he believes are inherent and ubiquitous in human beings but which show obvious and accelerated development under favourable psychological conditions. Such conditions are described by Rogers as the necessary and sufficient conditions for constructive personality change and notably associated with client-centred therapy.

There are three major dimensions of the directionality in Rogers' description of the "fully functioning person." These are: (1) "an increasing openness to experience," (2) "increasingly existential living," and (3) "an increasing trust in his (or her) organism (Rogers, 1961, 187-189). It is the extent of the development of the three directions in an individual that determines the extent of the psychological freedom of the individual. Psychological freedom is a process of growth, development and realization. Thus, it is through increasing openness to experience, increasingly existential living and increasing trust in one's organism that the inherent actualising tendency operates more effectively and fully. Rogers has described the psychological dimensions of the expression of the actualising tendency in human beings in his description of the "fully functioning person" (Rogers, 1961).

Rogers' and Maslow's theories of actualisation are often mistakenly equated. In addition to the differences in their views concerning the "hilly functioning" person, Rogers (1959) clarified a major difference between the theories early in his formulations when he defined the "actualising tendency" as the sole motivational construct. The motivations conceptualised as "deficiency needs," i.e., the physiological needs, needs for safety, belonging, love and esteem, hypothesised by Maslow (1970) as preceding the self-actualisation of persons, are included in Rogers' sole motivational construct.

**THE FUNCTIONAL ROLE OF THE ACTUALISING TENDENCY IN CLIENT-CENTERED THERAPY**

The fundamental notion of Client-Centered Therapy is that the therapist can trust the tendency of the client and the only role of the therapist is to create an interpersonal climate that promotes the individual's actualising tendency. Rogers adopted the construct of the actualising tendency principle as a cognitive underpinning that implied attitudes of trust in and respect for the client in a helping relationship. When a person has emotional disturbances and problems, according to Rogers' organismic theory, what is required to help the person is a situation or conditions that foster and facilitate the vitality of the person's innate recuperative and growth capabilities.

The therapeutic attitudes of trust and respect and the desirability of a fostering situation which can free the person's capacities for health and growth created some logical parameters for the therapist's approach. These parameters, in effect, eschew standard clinical thinking about psychotherapy, such as the need for diagnosis and treatment plans with treatment goals and strategies. Instead, it followed from the idea of the actualising tendency and the therapeutic attitudes of trust and respect that the therapist
need not conceptualise the client's illness, nor conceptualise any concrete goals that might affect the therapist's attitudes or behaviour in relation to the client. It also followed that the therapist need not engage in interventions, strategies or manipulations based upon speculations concerning the client's disturbance or upon ideas about what would constitute healthy directions for the client. It was also logically consistent that the therapist need not determine the frequency of therapy interviews, the length of the therapy, nor when the client should stop therapy. Instead, Rogers thought the client should be approached naively without preconceptions as a unique individual and be allowed to develop his/her own therapy process. The assumption was that the client's innate actualising tendency could be fostered most effectively by the creation of a distinctive interpersonal environment fundamentally based on the trust and respect that was implied by belief in the actualising tendency. The client would be given, in effect, control over the therapeutic situation and therapeutic process up to the limits of the therapist's capacity (and the demands of the work situation). The therapist's basic task is to listen with respect and understanding and help the client to clarify his/her feelings and thoughts as they are expressed to the therapist.

Rogers and his colleagues functioned with this philosophy of trust in the client and, as well, systematically researched their work (Cartwright, 1957). Out of all these endeavours Rogers conceptualised his theory of client-centred therapy. The specific features of the theory evolved out of and continued to be based on the organismic theory of the actualising tendency and the fundamental philosophy and attitudes of trust in and respect for persons.

**THE THEORY**

Client-centered theory posits the presence of a client who is incongruent, vulnerable and anxious but who is also in psychological contact with an attentive therapist. The therapist experiences and manifests three basic attitudes in the relationship. These attitudes are labelled as (1) congruency (or genuineness), (2) unconditional positive regard, and (3) empathic understanding of the client's internal frame of reference (Rogers, 1957; 1959). The particular manifestations or implementation of these attitudes is variable, within limits, depending upon the personal characteristics of both therapist and client. The theory also asserts that the therapeutic attitudes must be perceived to some degree by the client, Rogers hypothesized that the more fully and consistently the therapeutic attitudes are provided by the therapist and perceived by the client, the greater the constructive movement that will occur in the client (Rogers, 1959). The actualising concept functions in the practice of therapy by influencing the attitudes that are experienced and expressed by the therapist in relation to the client/other.

The client-centred therapist operates on a number of assumptions associated with the actualising tendency. These assumptions include:

1. Motivation is considered intrinsic, directional, and constructive; the person's tendency is for self-regulation and self-knowledge. The therapist is, thus, oriented to the world of the whole Person. The therapist eschews knowledge "about" the client, relates as an equal to the client, trusts and respects the client's perceptions as authority about him/herself and trusts the client.

2. The conception of therapy is one which provides a favourable to optimal psychological and personal environment for the client. The therapist is not precipitating change by manipulating or directing the client.

3. Consciousness/perceptions affect the person's behaviour. This assumption results in the need for the therapist's empathic atonement to the phenomenal world of the client.
4. The therapist attitude of unconditional positive regard is based on the organismic assumption that the person is always doing the best that he/she can under the particular existing inner and outer circumstances. The actualising tendency is the motive for changing circumstances that result in "doing better."

5. The disease or disturbance of an individual which responds to psychotherapy is due to inadequate environments (inner/perceptual; outer/physical-social) that distort or stunt realization of inherent capabilities. The therapist uses no other theoretical models to explain behaviours.

The basic client/person-centred value is that the authority about the person rests in the person, not in an outside expert. This value emphasizes the internal (i.e., the client's) rather than the external (i.e., the therapist's) view. The client is viewed as going in his/her own way, allowed to go at his/her own pace, and to pursue his/her growth in his/her unique way. The external view is meaningless in a constructive therapy process since the only function of the therapist is to facilitate the client's actualising process. Bozarth (1985) contends that Client-Centered Therapy operates within a different paradigm than other therapies because of the extreme focus on the "self authority" of the client. This focus on "self-authority" is buttressed in the therapist's trust and belief in the actualising tendency. Rogers (1986b) stated:

Practice, theory and research make it clear that the person-centred approach is built on a basic trust in the person... (It) depends on the actualising tendency present in every living organism's tendency to grow, to develop, to realize its full potential. This way of being trusts the constructive directional flow of the human being toward a more complex and complete development. It is this directional flow that we aim to release. (p.198)

The Functional Role of the Actualising Tendency in Therapy Practice

In the day to day work of the client-centred therapist, the idea of the actualising tendency remains a conscious cognitive foundation. It continuously supports the therapist's trust in, and respect for, the client and supports the therapist's inner activity of generating and maintaining the therapeutic attitudes of congruency, unconditional positive regard and empathic understanding in relation to clients. The remainder of this paper presents a segment from a therapy session that demonstrates the application of the trust and respect of the therapist that is predicated upon the fundamental notion of the actualising tendency.

Therapy Session Segment

This session is presented and then discussed in terms of the actualising tendency. The session is that of a female client with a female therapist. The female client is identified as "Angela." The client is depicted with, "C" and the therapist with, "T."

C-1 Over the weekend... its hard to explain. I noticed my pain, it was still there and I couldn't believe that I was functioning and feeling like a whole person. Even though I had the pain.

T-1 It was a new experience to have the pain coexist with a sense of wholeness.

C-2 Right Yeah, and I'm still not comfortable with that. If I don't keep after my doctors and myself... you know, things still aren't perfect... I just say o.k., it's liveable, so I can live like this. And I might end
up living with the pain when I could have gotten rid of it. I feel, if I don't keep after it, if I don't keep it in mind, and I don't keep bitching at my doctors, that somehow it's going to get lost... and I'll live that way.

T-2 But you won't have had to, (C: Yeah) you won't have had to have that pain continue but it will continue because you didn't keep at it.

C-3 Right.

T-3 If you don't keep vigilant.

C-4 Yeah, that's it And this other thing... when I don't feel good about my physical self... like... I went to the doctor and I gained a few more pounds and I'm upset about that. I was doing so well and so I decided o.k., that's it You know, I know I can do it, so I'm de-pressed that I even let myself gain a few pounds. It goes the other way, too. When I look in the mirror and I'll go, 'God, you look so good today, why do you feel so shitty?' I have this mental image with my weight too, if it's not where I want it to be, it's kind of like I walk around in my head, when my head hurts. I feel fragmented. If this is the way my inside feels, then this is the way my outside self is going to look to others. But it doesn't, I know that, but it feels like it is not right...

T-4 How you look and feel should be consistent, but it isn't that way and somehow you can't..

C-5 Yeah, It's like... sometimes I used to just look in the mirror and say, 'God, how come my pain doesn't show?' Cr Uh huh) where my pain is I imagine like cracks in my face, something concrete that I can see.

T-5 You would be shocked, 'how could it be?'

C-6 Yeah, I'd look in the mirror and I'd flip myself out, I'd just stand there...

T-6 'How could it be?'

C-7 Yeah... And when I'm feeling like that or when I'm feeling overweight or whatever, when I don't feel my body is physically in check, something feels, um, it feels like.... I don't know... it feels like I'm not a whole person... Which is, I guess, what's different about this past weekend, how I perceived myself, because... It's like I don't feel like a whole person when I'm like that and even though others can't tell... I feel like I'm being dishonest, Because they can't see what's really inside of me. I have a big problem with that, talking to people when I feel like shit, I feel dishonest because I really don't feel like I'm me. I feel angry, I feel depressed, I feel fragmented.. I got the word, it's a good client-centred word, I just thought, 'congruent', I don't feel congruent. That's what it is.

T-7 In your appearance and your behaviour, your appearance is one kind of person.... but inside you're...

C-8 It's that they're not congruent, they're different And to me that's why I can't feel like a whole person. But 'his weekend, I did feel like a whole person, even though I was still incongruent And it felt good, but, yet, it was upsetting too. Because then, I guess, I feel if I'm not vigilant that I never am going to be congruent.
T-8 The thing is you felt congruent, you felt (C-right) a whole person in spite of the fact that you still have the pain. So, you had the same combination of contradictory realities and yet you had a feeling of wholeness. (C-right) But there was the worry that you would, in feeling whole, let the pain stay by giving up on doing your utmost to get rid of it.

C-9 That's it.

A more detailed analysis of this therapy segment is presented in order to identify the relationship of the therapist's efforts to be consistent with the underpinning of the actualising tendency. The segment is from the fortieth therapy session. Angela's first response (C-1) illustrates her experience of surprise during the previous weekend. She says: "It's hard to explain" and, indeed, it is, at this point, not clear exactly what Angela means by "whole person" nor what her typical experience of herself may have been that made the weekend experiences so surprising. The therapist's first response (T-1) simply checks or tests understanding with a brief restatement for Angela to verify or correct. The therapist makes no attempt to pursue clarification or elaboration through questions or guesses. She simply expresses her understanding of the client as far as it goes. The therapist's trust is that the open acceptance of the client's statements will cumulate to foster the client's natural process of actualisation.

Angela (C-2) reveals that there is more to this surprising feeling of wholeness co-existing with physical pain. She says it was accompanied by a feeling of fear. The therapist (T-2) again tests her understanding by expressing Angela's point that she expects she would have to continue to live with pain if she were to accept the pain. Wholeness apparently involves accepting the pain. Accepting the pain means, to Angela, that she would give up pushing to find treatments.

Angela (C-4) verifies the correctness of her therapist's response (in T-2). The therapist then (T-3) responds with an emphasis on Angela's felt need for vigilance. The word "vigilance" was not used by Angela but is used by the therapist in her effort to understand the importance, to Angela, of keeping on the lookout for, and seeking treatment for, her pain. To this point, the therapist has consistently tried to follow the client's meanings and feelings by checking or testing her understanding with Angela. The therapist continues to trust Angela's own capacity for forward movement.

Next, in CA, Angela expresses two new points. The first point is that she doesn't feel good about herself. For example, because she gained weight, she says she must gain control. She expresses this as "O.K., that's it!", meaning that she must stop eating too much. She says that she can do what she needs to do when she reaches that point. The second point is expressed when she harks back to her first statement which had implied that previous to the weekend she had not ever been able to feel whole when in pain. Here (in CA) she is expressing a sense of confusion and disturbance when she feels "shitty" and at the same time is looking good. Apparently, previously she had not been able to reconcile this discrepancy between her feelings and her appearance into an experience of wholeness. Instead she would feel "fragmented."

The therapist is not able to complete her response (T-4) to Angela's C-4. But she again is trying to test her understanding. She does this in the form of a restatement of Angela's expectation of being consistent in her feelings and her appearance that is not realized in her actual experience of herself. The therapist does not attempt to explain or push Angela towards closure or resolution.

Angela (C-5) then vividly represents her previous point by quoting her thoughts when looking in her mirror and by stating the image she expects to see in her mirror. The therapist (T--S) responds by
representing herself as Angela, stating, in her own words, what might be Angela's words of shock when she finds her face in the minor is not racked and distorted as her pain makes her feel it might be.

Angela (C-6) further expresses her distress about the event of seeing she looks good while she's in pain. The therapist responds (T--6) by repeating what she said in T-5 as if they were Angela's thoughts or words, "How could it be?"

Angela (C-7) continues with a complex statement in which she first summarizes the basis for not feeling like a whole person. Then she restates the fact that the preceding weekend she felt whole while still experiencing pain. She then elaborates on the problem of feeling pain while looking good. She says it stimulates a feeling of being dishonest with people. Finally, still in C-7, Angela expresses her awareness of the therapist's client-centered approach with a positive emotional tone. She uses the Rogerian term "congruence" while explaining her new, recent, feeling of wholeness in the context of pain. In her response (T--7), the therapist starts to check her understanding by restatement, but is interrupted. Angela (C-9) verifies the therapist's grasp of what she has been expressing. Through the entire interview segment she actualising tendency construct has been functioning as an intellectual underpinning for the therapist's attitudes of trust in and respect for the client. These basic attitudes toward the client are channelled directly into the therapist's efforts to experience and express the specific therapeutic therapist attitudes identified by Rogers as congruency, unconditional positive regard and empathic understanding.

In the sequence of interactions between Angela and her therapist, Angela leads as she fills out the meanings of her initial statement (C-I) and adds other feelings that are related (e.g., C-2, CA, C-S). Angela's leading is a process of developing awareness, recollections and unfolding associations. How and what is revealed emanate from the process within Angela rather than from ideas put forth by the therapist. The therapist is not intervening with any theoretical conceptions whatsoever in Angela's actualising process (which includes self awareness and self-disclosure for Angela). The actualising tendency is immediately functional in the therapist's interaction with Angela. It is the basis underlying the attitudes that result in the therapist's non-interfering and non-directive empathic following of Angela's responses. The therapist's only verbal behaviour is her attempt to check or test her understanding of what Angela expresses. The question that is implicit in all of the therapist's restatements is, "Do I understand you correctly?" or "Is this what you are telling me?" Angela's responses indicate that she does feel understood. The therapist, thus, does not intervene, bring in "expert" suggestions or prescribe treatments. The therapist trusts the natural constructive direction of the client and strives only to implement the atmosphere that will foster the actualising tendency.

SUMMARY

This paper reviews Carl R. Rogers' concept of the actualising tendency as an operational premise in Client-Centered Therapy. Rogers' concept of the relation of the actualizing tendency and the fully functioning person is clarified. The role of the actualising tendency as a functional cognitive underpinning in Client-Centered Therapy is demonstrated by reviewing and commenting upon a client-centred therapy segment.

The client-centred therapist implements the actualising tendency by creating a specific interpersonal climate during the therapy session. This climate is created by means of the therapist experiencing and communicating certain attitudes toward the client. These attitudes are identified as the qualities of congruency, unconditional positive regard, and accurate empathy. These were considered by Rogers to be the necessary and sufficient conditions for constructive personality change. Since the experience of
these attitudes by the client fosters an individual's actualising tendency, the client-centred therapist trusts the client to move forward in a constructive direction without intervening and assuming therapeutic expertise about the client. The constructive forward movement of the client is propelled by the sole and inherent motivation in human beings; that is, the actualising tendency.

REFERENCES


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Client-centered therapy was originated by Carl R. Rogers (1902 – 1987). He developed the central concepts between 1938 and 1950, initially under the name “nondirective therapy,” only later changing the name to “client –centered” (Rogers 1951). The remarkable thing about this form of therapy is that right from the start it was marked by a duality (seen by some as an inconsistency) that ran through its entire development. On the one hand, Rogers is one of the leading personalities of humanistic psychology and accordingly human encounter, personality growth and the tendency toward self-actualization, trust in the self-healing potentialities of the individual personal liberty etc., are central to his approach. On this, Rogers (1973) cites Lao-Tzu, as quoted by Buber (1957), whom I already quoted in Chap. 12: “The perfect human being does not interfere in the life of others, he does not force himself on them, but helps all things to become free.”

On the other hand, however Rogers war one of the first therapists to systematically make sound recordings of the therapeutic interviews (initially, by the way, he did not use tape recorders, as is commonly claimed in the literature, since these were not reading available in the 1940s, but a device which as in the manufacturing process for records etched soundwaves into the recording material). These recorded interviews were not only used as the basis for training but also analyzed by empirical and statistical procedures to detect basic patterns of client-therapist interaction. Rogers was thus the first (apart from the pioneers of behavior therapy) to stimulate extensive experimental studies in which an attempt was made to operationalize the behavior of therapist an client, to measure it using rating scales, and to subject it to the classical methods of statistical analysis.

Since the beginning of the 1960s, the works of Truax and Carkhuff in particular have become known as blazing the trail for countless similar studies (see for instance, the more extensive overview in Truax and Carkhuff 1967).
This duality has its roots in Rogers’ personal biography. After 2 years of studying agronomy and then a radical change to theology at Union Seminary in New York City, he began to attend psychology lectures at the Teachers College of Columbia University, which was opposite the theological faculty. Soon he transferred completely to Teachers College, where he received an MA and then a PhD degree in education and clinical psychology. He thus received the major portion of his psychology training at the same institute at which Watson had developed his manifesto of behaviorism in 1913 and at which in 1924 experiments in behavior therapy were carried out under Watson’s direction. In 1945, in the same tradition, F. S. Keller, a fellow student of Skinners’s, and W. N. Schoenfield produced a curriculum to recruit scientists for the field of operant learning theories at Columbia University. It is natural that education at this Institute, in the mainstream of the ruling psychology in the United States at that time, with its “emphasis on scientific method, operational definitions, and the proof or disproof of hypotheses” (Rogers 1980), should have had an impact on Rogers’ basic convictions and attitudes towards research.

On the other hand, however, Rogers, and hence the development of his therapy, was substantially influenced by the existential philosophy of Kierkegaard and Buber and by the gestalt psychology defended by Kurt Lewin (see Chap. 13). Another important influence was his contact with Freud’s disciple Otto Rank. Rank asserted emphatically that the patient must be responsible for his own life and for the form of the reality he creates for himself, and stresses how necessary it was that the client express his personal will. Pfeiffer (1980) points out that the essential elements of Rogers’ concept of the tendency to self-actualization and of centering the therapeutic work on the experiencing of feelings, on increasing congruence, and on changing the perception of the self, are already to be found in Ranks’s work. Rogers himself also mentions a personal component in the development of this approach: “As I look back I realize that my interest in interviewing and in therapy certainly grew in part out of my early loneliness” (1980 p. 34).

After some decades in which research was focused on empirical data and statistical analysis, a recollection of humanistic psychology and of Carl Rogers’ actual position has now emerged in client-centered psychotherapy, especially since Rogers’ own base position became more and more phenomenological and existential (although there is also an opposite trend in client-centered therapy, which we will discuss later on). There is a drastic difference for instance between the first six editions of the classical German standard work in this field,
Gesprächspsychotherapie by Tausch, and the newer editions (from 1979 on). Until 1978 the reader was proudly led through cemeteries of data filled with correlations of 0.30 and 0.40 which, though significant, explain only 10% to 15% of the measured variance. Since then, these data have faded into the background, terms like “helpers,” “partners” and “persons” are used, and examples and explanations are used more than numbers. Nevertheless, a clearly formulated model of the effectiveness of client-centered therapy is still lacking. Empirically based research in psychotherapy is unquestionably necessary and desirable, but as long as there is no clear theoretical formulation of what the therapeutic interpersonal relationship in client-centered therapy is and how it works, over euphoric data gathering is bound to pass right by the unknown core.

Thus, in the 1970s more and more attempts were made towards forming a new theoretical model refining existing concepts. This was accompanied by a shift from large univariate surveys to multivariate microanalyses (e.g., Howe 1980), the significance of which remains to be conclusively assesses. Minsel and Bente (1982 p. 46), at the end of their very critical overview of the development and current state of client-centered therapy, stress that more time and energy should be devoted both to theory and to the actual events during therapy a complex multivariate process.

7.1 Periods of development of client-centered therapy

As already mentioned, the basic concepts of client-centered therapy were modified a number of times over several decades. In general, a rough division into three or four periods with different accents can be established. Hart (1970), Pavel (1975) and Minsel and Bente (1980e an three-period-division; Shlien and Zimring (1970) name four. These stages are not separate and distinct, but overlap in time; moreover it should be remembered that the approaches have become far more heterogeneous in the last 15 years. The following four-period presentation is intended only to provide a rough orientation in a process that produced increasingly divergent currents. I will keep to the central concepts; criticisms and lines of development departing very far from these central concepts will be only briefly mentioned.

7.1.1 First Period: nondirective therapy (1940s)
The first basic concepts were developed between 1938 and 1950 particularly in Ohio (1940 – 1945) and Chicago (1940 – 1950). The focus is on nondirective counseling (Rogers 1942), in which the objective is to offer the patient an situation in which he can feel safe and secure. The therapeutic intervention is permissive and nondirective: that is, the therapist does not try to direct the patient. Instead, warmth, empathy and unqualified acceptance are the therapist’s basic attitudes. This form of therapy rejects the “medical model,” especially the elements “diagnosis of disturbance,” “specificity of treatment” and “effort to cur.” “Patient” is replaced with “client.” Disturbance is understood less as an illness than, as a lack of awareness and thus a growth deficiency. The emphasis is on the self-responsibility of the client, for whom the therapist creates an climate in which the client can make his own discoveries and decisions; by no means should he consider himself an object of treatment.

7.1.2 Second Period: verbalizing feelings (1950s to mid 1960s)

The heated discussion on nondirective counseling (Rogers 1942) together with a larger number of empirical studies an therapy, led to a shift from nondirectiveness to client-centering, in which the therapist is given a broad spectrum of interventions within the limits of the basic attitudinal conditions (see below). In this client-centered therapy (Rogers 1951), the client learns to confront the world of his own feelings. The therapist’s task is on the basis of the facilitative attitudes described for the first period, to help the client attain a better self-concept and a reflection of his feelings (self-exploration). The emphasis in the therapist’s role changes accordingly, from trying to cognitively clarify the client’s problems to encouraging the client to verbalize his feelings (and thus the values and perceptions associated with them). The “self-concept” becomes the key concept in the theory of personality and of the therapeutic process postulated by Rogers.

In this period, too, Rogers developed the concept of the tree basic attitudes as necessary and sufficient conditions for successful therapeutic behavior (Rogers 1957). These relate to the therapist’s attitude and are:
(a) positive regard and emotional warmth (acceptance),
(b) congruence (self-congruence), and
(c) empathetic understanding (with the technical emphasis on verbalization of the content of emotional experience).
These three basic conditions will be discussed in detail below (see Sect. 7.4).

7.1.3 Third Period: centering on experience (from the 1960s on)

Since about the 1960s, the pure verbalization of emotional content which the client brings into therapy has been losing significance and the relationship between the therapist and the client in the therapeutic process itself has taken on more importance. Building further on the attitudes and basic conditions of the first and second periods, the main weight of the therapeutic intervention is directed at preserving the intensive contact between therapist and client, and, even more, the contact of the client with himself, i.e., with his frame of experience, the way he perceives his feelings, attitudes, and reactions. To this end, more and more forms of intervention that promote experiencing are integrated into client-centered psychotherapy for instance, the “experiencing” and “focusing” concepts of Gendling (see. Sect. 7.6).

These beginnings of a broadening of the basic concepts (a process which went on in the 1970s to become much more comprehensive and radical) ran parallel with a growing doubt on the part of Rogers’ followers as to whether the conditions formulated above were really “necessary and sufficient” for therapy. In the 1960s, reservations were also expressed regarding the empirical content of the theory and its precision and testability (e.g., Ford and Urban 1963). Further, empirical studies yielded more and more negative results regarding the effectiveness of the basic attitudinal conditions (e.g., Truax et al. 1965; Bergin and Jasper 1969; for critical summaries see Mitchell et al. 1977; Minsel and Zielke 1977; Zielke 1979).

The growing doubt and criticism even within Rogers’ own camp, are to be explained by the fact that the high respect accorded Rogers among clinical psychologists and the strong support he receives from empirical research (which psychoanalysis) did not attracted many people who did not share his philosophical position, while Rogers absorbed more and more humanistic and existential-phenomenological elements into his thinking, the number of client-centered therapists whose emphasis was on aspects related to learning theory or communication theory steadily grew.
7.1.4 Fourth Period: expansion and integration (from the 1970s on)

The last decade has been one of increased innovation with regard to the basic concepts of client-centered therapy, going far beyond simply shifting the accents within the client-centered therapeutic approach, a possible interpretation of concepts such as “experiencing” and “focusing”). Attempts have been made to adopt many approaches, theoretical concepts and intervention techniques from other forms of therapy and integrate them into client-centered therapy. An important work in this connection is a book by Wexler and Rice (1974) entitled Innovations in Client-Centered Therapy, in which 17 authors discuss modifications and extensions of Rogerian concepts.

Major expansion was undertaken by Martin (1975), for instance, with respect to the conflict theory; by Tscheulin (1975) towards integration of communication theory aspects of the Palo Alto school (see Chap. 18); and by Wexler (1974) in connection with concepts from information theory and cognitive psychology. For a revival of client-centered child psychology (Schmidtchen 1974), developmental and social-psychological aspects were added to Rogers’ basic concepts and those of Axline’s early child-therapeutic approaches (Axline 1947). Recently, Howe published two collections (1982a,b) which clearly reflect a strong trend toward integrating various approaches into client-centered therapy despite decided objections by, for example, Biermann-Ratjen et al. (1980). In their 1970 book on client-centered therapy the latter present a well-argued attempt towards an understanding of how this therapy works; reformulating Rogers’ concepts, they move “changing through understanding” into the center of attention.) Client-centered encounter groups or group psychotherapy are also gaining in importance an development that Rogers himself promoted (Rogers 1970; Franke 1978; Tausch and Tausch 1979).

In spite of this extreme heterogeneity at the present stage of development, the following presentation of the central constructs will remain closely oriented toward Rogers’ client-centered therapy, although the in my opinion very fruitful aspects of Grendlins’ centering on experiencing and the reformulations of basic client-centered psychotherapeutic concepts by Biermann-Ratjen t al. (1979) will also be mentioned.

7.2 Rogers’ view of man and theory of personality
Most of Rogers’ elaborations on his theory of personality are interwoven with personal experience, with his existential, humanistic view of man, and with philosophical concepts of the processes of teaching, learning, and experiencing. Trying to separate the individual aspects would be like “pulling out the warps from the woof in woven cloth” (Bischof 1964). Rogers gave the clearest, most explicit presentation of his thinking on the theory of personality in 1951, in the form of 19 hypotheses (nevertheless, many people still complain of an lack of consistency, especially the gap between theory and practice; see e.g., Zimring 1974; Grunwald 1976; Bommert 1977). Essential elements of his view of man are included in practically all his publications.

One of the central concepts of Rogers’ theory of personality is the self, which in the course of childhood development becomes differentiated out from the child’s visceral perceptions in his interactions with the environment. The self first of all organizes and structures experiences, but it also denies or distorts these if they are not consistent with the self-image. Equally important is the tendency toward self-actualization, which Rogers defines as “the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism.” However it requires a conducive physical and psychological environment in order to function or it may come to a standstill. The third central aspect is incongruence, the discrepancy between the organism’s experiencing and its self-concept. Where the incongruence is great, the self-actualization tendency leads to conflict: on the one hand, it supports the self-concept and touches up the self-image, but on the other the organism is striving to fulfill its need, which can only be done by accepting reality including those aspects of it which are incongruent with the structure of the self. The organism and the self are thus pushing in different directions, the gap between self and reality widens, and the conflict that results is the source of anxiety (Rogers 1980).

Rogers’ 19 propositions concerning personality are taken from Rogers 1951, pp. 483-522. As they are self-explanatory, I shall add no statements, but will pick up many items again in the discussion of basic therapeutic attitudes and on the therapeutic process (see Sects. 7.4, 7.5):

1. Every individual exists in a continually changing world of experience of which he is the center.
2. The organism reacts to the field as it is experienced and perceived. This perceptual field is for the individual “reality.”

3. The organism reacts as an organized whole to this phenomenal field.

4. The organism has one basic tendency and striving to actualize, maintain, and enhance the experiencing organism.

5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.

6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.

7. The best vantage point for understanding behavior is from the internal frame of reference of the individual himself.

8. A portion of the total perceptual field gradually becomes differentiated as the self.

9. As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed an organized of characteristics and relationships of the “I” or the “me,” together with values attached to these concepts.

10. The values attached to experiences, and the values which are part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in a distorted fashion, as if they had been experienced directly.

11. As experiences occur in the life of an individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, (c) denied symbolization or given a
distorted symbolization because the experience is inconsistent with the structure of the self.

12. Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of the self.

13. Behavior may in some instances be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not “owned” by the individual.

14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension.

15. Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.

16. Any experience which is inconsistent with the organization or structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.

17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences.

18. When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others and is more accepting of others as separate individuals.

19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system based so largely ...
7.3 Basic attitudes of the therapist

As we have mentioned, 1957 Rogers formulated three attitudes on the part of the therapist that are necessary and sufficient for constructive therapy. These are frequently called the basic conditions or of therapeutic behavior. This notion of therapeutic behavior is slightly misleading, as Rogers was not so much concerned with introducing “behavior” variables (in the sense of Skinner’s “verbal behavior,” for instance) as exact parameters of a technique or “treatment method,” but rather with describing aspects of an interpersonal relationship in therapy to create a growth promoting climate in which positive change is possible. Yet, when communicated within the framework of a more or less technical view of psychotherapy, these basis attitudes are often drilled as behavior variables in technical training sessions, with the goal of scoring as high marks as possible for each of them.

To accentuate the humanistic approach of client-centered therapy more strongly, instead of three separate basic conditions or attitudes I will speak of three aspects of one encounter-attitude: the therapist and the client encounter each other as partners, although with different purposes. In this encounter, the client should be able to experience that the therapist is accompanying him with understanding as he explores his self, that he is encouraging him by his attitude, without judging and that he accepts him and his problems without trying to take over responsibility for them. Although the emphasis here on the “three aspects of one encounter-attitude” is intended purely phenomenologically in the light of the empirical findings it certainly to be meaningful: many researchers have found a correlation coefficient of 0.70 between the three aspects (recorded as “behavior variables”) far higher than any normally found in this field (see also Wiggins 1973 and Grunwald 1976, who also question the idea of three separate variables).

7.3.1 Unconditional positive regard
This complex element of the therapist’s attitude is described by such terms as “acceptance” and “respect.” It refers to the therapist’s ability and willingness to experience the client as a fellow human being and to enter upon an existential encounter with him, without categorizing him on the basis of his actions, qualities and word. Thus, the key question is whether the therapist is able to perceive the human being in the client, or only to react (because of his own problems, stereotypes he has learned, etc.) to a bundle of roles, actions, and words, which he then assesses and categorizes. Unconditional acceptance does not at all mean that the therapist has to approve of the client’s actions or share his attitudes; means that, beyond this superficial structure, he can feel a deep respect for human life as it is manifested in the way the client is. In this context, Rogers speaks of love in the theological sense of ‘agape’ feeling that is neither patriarchally caring, nor sentimental, nor superficially kind. It seems more than doubtful that such feelings can be “taught” or “learned” and “trained.” Positive regard and emotional warmth are manifested at the behavioral level by the therapist’s not trying to impose his own opinions and values on the client, not giving advice and recommendations, etc. For the purpose of empirical research, Truax (1962) devised a five-point “scale,” by which observers can assign the therapist to particular categories for these variables and express this rating as a number.

A therapist who can experience positive regard for his client and can communicate emotional warmth to him will elicit similar feelings in the client towards his self, so that the client is able to respect and accept himself better (Biermann-Ratjen et al. call this “establishing an empathic internal object.”) The client also learns to differentiate between his value as a person and evaluating his actions.

7.3.2 Congruence

The aspect of being in an encounter also has a number of other names, such as “genuineness” “self-congruence,” “self-honesty,” “being without a facade,” or “self-integration.” In humanistic psychology congruence presupposes a mature personality, one that does not hide behind facades and meaningless words a person who is open and is not neurotically anxious and defensive about his own feelings and perceptions, but is willing to experience himself, to be himself, and to bring this self fully into the situation. The important thing, is that the therapist responds as a “whole person” (in the humanistic psychological sense) and is truthful
in the relationship; he is aware of what he experiences and expresses this honestly in the
course of communication. It is the therapist’s human substance that is needed not some
technique or skill he has learned.

At the level of behavior, congruence is shown when the content of what the therapist says and
the tone of voice, facial expression and gestures accompanying it agree, and when he is able
to make spontaneous use of a large repertoire of responses. A number of scales have also been
designed for this variable (e.g., Truax 1962; Carkhuff 1969).

Congruence on the part of the therapist allows the client to be trusting. The therapist makes
himself transparent to the client, and the client can experience nonverbally/analogously the
same thing that he hears verbally/digitally; he can see through the therapist. Only if he has
such trust in the therapist will the client be willing to open, share, and discover his own
person, rather than cautiously observing him as an opponent.

7.3.3 Empathic understanding

Other terms for the aspect of therapeutic encounter known as “empathic understanding”
include “empathy,” “understanding,” and “nonjudgmental interest.” From the point of view of
intervention technique this variable is known as “verbalization of emotional experiencing”
(VEE). The therapist attempts to understand his client in the latter’s experiencing (and his
values, motivations, wishes, and anxieties). In the literature, this attitude is often paraphrased
as the therapist looking at the client’s private world with the client’s eyes, from the client’s
internal frame of reference. Such descriptions, however risk giving rise to misunderstandings.
Davison and Neale (1978.p.493), for instance, point out the “epistemological problem” of
“...how a therapist is to make an inference about internal processes of which the client is
seemingly unaware....” For this reason, it must be emphasized that empathic understanding is
not a static diagnostic “seeing through,” but rather a dynamic process on the basis of the offer
of the relationship (see Biermann-Ratjen et al.1979), in which at the beginning almost all of
the “internal processes” of the client are unknown to both the client and the therapist. The
therapist’s efforts to understand the client empathically, his signaling that what is going on in
therapy is teamwork, and the client’s experience of feeling understood give the latter the
courage to gradually explore his internal processes himself, accompanied by the therapist.
The technical component of this third basic attitudes, verbalization of emotional experience, is the most “trainable,” but without the two precious elements it remains an artificial technique, the positive effect of which is doubtful, to say the least. Essentially the therapist gives the client constant feedback by expressing in his own word what he has understood of the client’s experiential content the feelings, perceptions, and experiences bound up with valuations. The therapist does not “reflect” the client’s statements (as it is sometimes incorrectly put), but works very selectively in picking up the feeling and experiential content that he has heard in the client’s statement. But he should proceed with as little interpretation and evaluation as possible, using no therapeutic diagnostic blueprints: his feedback must be verifiable by the client’s statements (of course an element of interpretation will always remain interpretation). Biermann-Ratjen et al. (1979) show with copious examples how important it is for the therapist to bear in mind the client’s frame of reference. The more the therapist can comprehend of what lies behind the client’s verbalizations, in terms of personal experience, mode of experiencing, the way in which the client is affected and the more adequately the therapist can convey his empathy. The training of verbal expression is directed only at a superficial phenomenon: the important thing is whether the therapist is even able to perceive and understand the range of the client’s feelings and experiences, and the less he perceives his own feelings and perceptions the more neurotically he blocks out certain aspects of his own experience the less likely he is to succeed.

Thus, an essential part of the therapist’s training is like analysis an comprehensive self-experience or personal therapy, in which problems, defense mechanisms, and prejudices which would make the therapist see the client’s problems in the light of his own problems and framework, and which would prevent him from encountering the client openly and freely, can be worked through. Only against this background can the formal elements of therapeutic intervention as Minsel (1974) describes them be helpful. Minsel gibes the following tips: intervene as often as possible; formulate briefly concretely and clearly; avoid ambiguity.

Since, as I said, of the three attitudes empathic understanding is the most observable as a “behavior variable,” VEE has been the most frequent subject of empirical investigations. Accordingly, there are a large number of “scales” according to which this behavior can be categorized and rated with numbers. The most frequently found scales in the literature are a five-point rating scale by Carkhuff (1969) and a six-point scale by Tausch et al. (1969), plus...
slightly modified versions of these. Their range is to put it roughly, from “no picking up any feelings,” to “verbalizing non-important feelings,” to “verbalizing all important personal and emotional contents of experience.”

Let me say in conclusion that in the literature on client-centered psychotherapy the following series of “non-classical therapist variables” are discussed (Rieger and Schmidt-Hieber 1979); for a short summary see “specific concreteness” (Truay and Carkhuff 1964); “active efforts (and inner participation)” and “confrontation” (Bommert 1977 pp. 73, 51); “interpretation” (Howe 1962, Tausch 1973 p. 159); “specificity” (Helm 1972 p. 39); “self-introduction” (Carkhuff 1969); “likability” (Tausch 1973 p. 152); “linguistic activity” (Minsel et al. 1973); and “persuasive potency” (arousing trust and hope, Frank 1961). This abundance of literature is an indication of how complex Rogers’ constructs are, and how difficult it is to reduce them to the level of empirically observable “variables.”

7.4 Psychic disturbances and the therapeutic process

In accordance with Rogers’ theory of personality, a therapist-client relationship which is essentially characterized by the three attitudes just describes is able to trigger off a process which releases the forces of self-healing and self-actualization that are buried in the individual. Through the release of these forces, in a climate marked by respect, congruence, and understanding, the client develops more autonomy (instead of dependence), self-acceptance and self-respect (instead of self-rejection), awareness of his experience (instead of distortion), flexibility (instead of rigidity), and courageous creativity (instead of timid conservative control and over-conformity). These terms also describe the goal of therapy, which is reached with the help of the tendency toward self-actualization: the “fully functioning person.” Perhaps we should just briefly touch on the question of how a drive as strong as the tendency toward self-actualization can come to be buried in the first place.

Several points of relevance to psychic disturbances were already made in personality propositions, 10, 11, 13, 14, 16, and 17 (see Sect. 7.3): as long as the self-structure, that is, “the organization of hypotheses for the encounter with life” (Rogers), is consistent with the environment, a positive self-feeling can exist. Conscious tensions are few since there is no contradictory material to cast doubt on the appropriateness of the self to experience. however,
it may turn out that the inner conflicts grow when the self-structure is no longer appropriate
(Rogers takes the example of the star pupil of a small-town school, who perceives himself as
“brilliant,” and who on going to university is confronted with experiences that do not fit his
previous self-concept. The perceptions that threaten the structure are either denied, distorted,
or inappropriately symbolized. Without a relationship like the therapeutic one described
above, a pathological process can set in, when the threats reach a certain point, in which the
perceptual distortions can narrow the experience, and this in turn intensifies the distortions or
at least maintains them. In the “strict, hard gestalt that is typical of every threatening
organization” (Rogers), the living effectiveness of the tendency toward self-actualization is
frozen.

In an approximation to a depth psychological model of development, Biermann-Ratjen et al.
(1979) have worked out that such denials and distortions in problematic situations can be
traced back to experiences in early childhood during the development of the self), when the
person felt a lack of regard and empathy on the part of those to whom he related most
closely. Because a child is highly dependent on respect and regard, he denies experiences
which jeopardize this regard, (as in Alice Miller’s Thou Shalt Not Be Aware, 1984); he only
feels and experiences what his parents want to the point of distorting or denying experiences
in which he felt disregarded and humiliated. But according to Biermann-Ratjen and Eckert
(1982 p. 38), “It is not the pain of early childhood that is dangerous, is tragic; the danger lies
in the fact that a person’s own access to his experiences, of which pain is one, can be
obstructed.” In connection with the later actualization of these early experiences triggering
the process describes above, Rogers points out (1951) that in homogeneous cultures
“unrealistic” perceptions are largely unproblematic, but in our modern culture with its
conflict-generating subcultures and its contradictory values, goals, and perceptions, the
individual is exposed to a realization of discrepancies in his perceptions.

The offer of a therapeutic relationship as describes above allows the client to experience an
absence of threats, a feeling of being accepted with his doubts, his vague perception of
himself, and his insecurities. Every aspect of his self that he carefully exposes and explores is
accepted in the same way. Threatening experiences and insights also emerge, and at first the
client temporarily falls back on the earlier, comfortable gestalt, but then he begins slowly and
cautiously to incorporate these contradictory, threatening experiences into a new and revised
structure. Rogers describes this therapeutic process the “process of disorganization and

...
reorganization” in many different way (e.g., 1951, 1961) and suggested a seven-level therapeutic process scale (1958) on which he categorized the development according to seven process variables. This yields $7 \times 7 = 49$ categories, which, however, Tomlinson and Hart (1962), for instance, reduced to $7 \times 3 = 21$ by combining levels 1/2, 3/4 and 6/7. Truax (1962) made another kind of reduction by consolidating the seven process variables into one, called “self-exploration” (SE, a scale frequently used in therapeutic research). I shall use the seven process variables here to outline the changes in the therapeutic process, and will give the extremes for each:

1. feelings and personal opinions are neither expressed nor recognized at level 1; at level 7 they are experienced and expressed as immediately present,
2. the mode of experiencing at level 1 is rigid and largely unconscious, meanings are barely symbolized, and the present is interpreted in terms of the past; at level 7 the client lives in the process of his immediate experiencing, freely and accepting.
3. at level 1 the client is largely incongruent without noticing it; at the middle stages this incongruence is often experiences; at level 7 there is very rarely any incongruence.
4. communication about the self is completely lacking at level 1; at level 7 it is possible at any time the self is embedded in immediate experiencing.
5. the cognitive structuring of experiencing is rigid at level 1 and the structures are regarded as external facts; at level 7 the structures are flexible, can be tried out experimentally, can be changed by every new experience.
6. problems are not recognized at level 1 and the wish for change is lacking; at level 7 the client perceives problems and his own share in them, and assumes responsibility for this.
7. at level 1, the client considers close relationships with others to be dangerous and avoids them; at level 7 he seeks free, open relationships with others on the basis of immediate experience.

These extremes are only for of purposes orientation: Rogers himself points out that a person who operates at level 2, for all process variables presumably would not have even gone to therapy voluntarily in the first place, while a person at level 7 would have long outgrown therapy. Biermann-Ratjen et al. (1979) emphasize that level 1 to 7 are not to be understood as phases of therapy, and most certainly not as stages on the way to maturity. Rather, they are “stages a person goes through to gain access to his feeling, which is somehow important for him, but from which he has been cut off.” Consequently, with each new problem that he
confronts in therapy, the client may “regress” to lower levels. Biermann-Ratjen et al. characterize client-centered therapy as a process in which the client is moved from the relationship he has to himself one, that he himself and/or others experience as being deficient, ungratifying, rigid etc. into another relationship to himself which is identical with the relationship offered to him by the therapist.

7.5 Experiencing and focusing

An important expansion of the “classical” client-centered therapeutic approach involves the concepts of experiencing and focusing introduced by Gendlin (1961, 1964). They are presented here because they fit in so well and because they were developed in collaboration with Rogers.

Experiencing is a primarily theoretical construct which arose in the efforts to improve Rogers' scale for measuring the therapeutic process especially to increase its validity and to take the high intercorrelations between the process variables into account. Experiencing is thus a scale with which one tries to reduce the therapeutic process to one central aspect, the client’s immediate experiencing of feeling (The American Manual was published by Klein et al. in 1969). The experiencing concept has become the core of an independent theory on the change of personality (Gendlin 1964), and there is even an independent school of therapy called Experiential Psychotherapy (Gendlin 1970). Dahlhoff and Bommert (1978) offer the following definition of experiencing:

“Experiencing” means the concrete, immediate experience of an individual, in which the attention is focused on an underlying, felt object of experience. The object does not necessarily have to be capable of complete description in words; for the individual concerned it is more a physically felt relationship: an immediate felt, personal meaning of things and experiences.

A key element is the “felt meaning” an implicit object of experience not yet symbolized in word (to my knowledge) no connection has yet been drawn with research n the hemispheres of the brain here, the right hemisphere or the various representation systems of “neurolinguistic programming”; see Sect. 19.1.2. The authors of the seven-level scale (Dahlhoff and Bommert 1978) summarize it as follows:
Levels 1 – 3: The personal role of the speaker in experiencing cannot be perceived; that is, the viewpoint of the speaker is outside his immediate experiencing (as if another person were reportin).

Levels 4 – 7: The content verbalized is looked at from an internal standpoint, that is, from a standpoint located within internal experiencing and feeling. An increasing amount of intensity and change in the felt meaning is described.

Here we can see not only a close relationship to Rogers’ scale for measuring the therapeutic process but also an enrichment of the therapist’s intervention, in a way which is consistent with the basic attitudes of client-centered therapy: the client is challenged to deepen his experiencing. This process, which Gendlin(1964, 1970) named *focusing*, is the process of letting a felt sense take form and differentiating it into new perceptions and feelings. It is divided into the following four stages (Bense 1979):

1. **direct reference:** The client first puts aside his opinion “of himself an what is like” and concentrates on what he is immediately experiencing. What is being experienced cannot yet be clearly verbalized often the client talks only vaguely about “this.”

2. **unfolding:** Out of the vague “this” comes a feeling of “I’ve got it,” something which often surprises the client. Even if the object of experience is not positively evaluated, client reports and physiological measurements show that there is a reduction of tension. As with anticipatory anxiety, people would usually rather know about something unpleasant than remain in uncertainly.

3. **global application:** The client achieves direct access to different areas of experience. Objects of feeling which preciously seemed unconnected can be linked by the changed felt meaning. Gendlin stresses that this does not mean “insight” in the usual sense (this reminds us of Jung’s “intuition”, see Chap. 4).

4. **referent movement:** After stages 1 – 3, new implicit meanings of the object of experience are now felt; old ones fade into the background. the old object has been changed by this
process often to the surprise of the client. A new felt meaning now exists, and the four-phase process can begin again.

Gendlin points out that these four phases are not always distinct and do not always take place in the order shown above. Various authors (e.g., VandenBos 1973) have already tried to interpret focusing-capacity as an “personality variable” in the sense used in differential psychology. In this context, however, it is interesting that focusing can be connected with VEE. As early as 1951 Rogers had said: “For behavior to change, a change in perception has to be experienced. This cannot be replaced with intellectual recognition.” Focusing could support this process.