

**AN INTRODUCTION TO PERSON-CENTRED COUNSELLING PSYCHOLOGY**

**Professor EWAN GILLON**

**CHAPTER 3 – A PERSON-CENTRED THEORY OF PSYCHOLOGICAL THERAPY**

## Introduction

As we saw in the previous chapter, Rogers' (1959) theory of personality posited *incongruence* between organismic experiencing and the self-concept as the sole cause of all psychological disturbance. Following on from such a view, it is the reduction of incongruence that is associated with greater psychological wellbeing and, as such, provides the rationale for a person-centred approach to psychological therapy. In this chapter we shall explore the person-centred therapeutic approach, highlighting how it works to reduce incongruence in the ways initially described by Rogers (1957), as well as those subsequently developed by others within the framework (e.g. 'experiential' practitioners)

## A theory of therapy

Since first outlining his ideas for psychotherapy in the early 1940s, Carl Rogers consistently highlighted the role of the relationship between client and counsellor as of primary significance in therapeutic practice. This was a stance that evolved from his own experiences of working as a psychologist, and informed by his awareness of a wide range of other psychological theories and approaches. Rogers saw an effective therapeutic relationship as denoted by the presence of a systematic series of counsellor attitudes in conjunction with certain factors primarily linked to the client. If each of these dimensions were in place, he argued it was *inevitable* that psychological growth would occur.

In 1957 he published a paper entitled *The Necessary and Sufficient Conditions of Therapeutic Personality Change* in which he detailed six conditions which were 'necessary and sufficient' for psychological change to occur within a client. Rogers deliberately used the word *sufficient* to make it absolutely clear that these conditions, if met, were enough to produce change. Nothing else was needed. Indeed, he saw further techniques or methods drawing on the expertise of the therapist (such as advice-giving or interpretations) as an irrelevant sideshow.

This paper is now known as his *integrative statement* (Wilkins, 2003) because it was designed to be relevant to all psychotherapy and drew on research and analysis from a

range of psychological approaches, not simply person-centred therapy. Hence, Rogers' (1957) proposition was that *any* relationship possessing the conditions he specified would produce psychological change within the client, irrespective of whichever psychological approach was employed. For him, psychoanalytic and behaviourist approaches would thus be equally effective if the relationship between client and therapist in these contexts possessed the same qualities, and in the same measures, as those offered within a person-centred therapeutic context. What really mattered was the relationship a therapist had with his or her client, with psychological change *guaranteed* if this relationship met the following conditions (Rogers, 1957):

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

Although there is some discussion over the precise terminology of the conditions as stated (c.f. Embleton-Tudor et al. 2005), the emphasis on relationship is clear. In general, the 6 conditions are considered as to have two basic components, those associated with the actions and experiences of the therapist (conditions 3, 4 and 5), and those linked to the client's experiences and capacity to engage in a therapeutic relationship. Conditions 3, 4 and 5, the so-called 'therapist conditions' (Barratt-Lennard, 1998) are often termed the *core conditions*, and are those most often referred to within other therapeutic orientations (e.g. Egan, 1998) as well as providing the focus for much research and analysis (e.g. Norcross, 2002). They are seen as *core* because they concern the conduct the therapy itself and are thus often seen as the vehicle through which change is enabled. Each is seen to play a different, but equally important, part in facilitating a client to become more congruent.

## The 'core' conditions

The three core conditions, empathy, unconditional positive regard and congruence, present a considerable challenge to the person-centred practitioner, for they are not formulated as skills to be acquired, but rather as personal attitudes or attributes 'experienced' by the therapist, as well as communicated to the client for therapy to be successful (this latter requirement is stated in condition 6). Congruence (condition 3) is somewhat different but again seen as a quality of the therapist, rather than an action or skill. This emphasis on personal attributes served to counteract any existing notions that person-centred therapy is simply a mechanistic process of non-directive repetition in the presence of warmth (as often simplistically understood). However, in placing the emphasis upon the therapist to *experience* particular qualities, and to *communicate* these in such a way that is, at the very least, minimally achieved (condition 6), Rogers highlighted the very personal nature of the therapeutic relationship he envisaged.

For Rogers, therapeutic work is an inherently *personal* task with its success wholly dependent on the capacity of the therapist to enter into an *experiential relationship* with a client, not hide behind professional masks or intellectual expertise. This capacity is not acquired through formalised academic learning or by training to be a professional psychologist (although such knowledge is important to support such work), but through self-development and personal growth activities, such as group and personal therapy. Indeed, he later described this capacity, once developed, as a 'way of being' (Rogers, 1980), suggesting at times that the very 'presence' of another person offering these qualities is sufficient for psychological change to occur (Rogers, 1986).

### **Box. 1 Non-Directivity and the Therapeutic Relationship**

Although often not stated directly, the principle of non-directivity is often seen to remain at the heart of Rogers' person-centred approach to therapy (e.g. Grant, 1990). It is enmeshed in the 6 conditions identified by Rogers in 1957, and in particular the conditions of therapist empathy and unconditional positive regard. In being committed to offering these attitudes, a person-centred counsellor does not attempt to take control of a client's experiencing by diagnosing particular psychological disorders or by instructing a client how best to deal with the problems he or she encounters. Instead, the client is viewed as the expert on his or her own life, and accordingly supported to exercise autonomy in making choices (Merry, 1999). As a result of this non-directive approach, the client is enabled to grow in accordance with his or her unique attributes, and fully

trusted in this process. A commitment to non-directivity represents, at its most basic, a fundamental person-centred belief in the client's actualising tendency, or in other words her capacity to function as an autonomous, constructive and self-regarding being.

The notion of non-directivity is a highly controversial aspect of person-centred theory, with critics such as Kahn, (1999) arguing that it renders a therapist passive in the face of all client desires or intents, as well as denying the inevitable impact of the counsellors own views and ideas on the counselling process itself. However, Mearns and Thorne (2000) propose that the whole question over non-directivity is misplaced, for like in the 1940's, the idea is often misinterpreted as a behaviour rather than an attitude or principle. Instead it is better seen, as Merry (1999) suggests as " a general non-authoritarian attitude...it refers also to the theory that the actualising tendency can be fostered in a relationship of particular qualities, and that whilst the general direction of that tendency is regarded as constructive and creative, its particular characteristics in any one person cannot be predicted, and should not be controlled or directed" (p.75-76).

## Empathy

Empathy is perhaps the most well-known of Rogers' therapeutic conditions, and is certainly the one which attracted the most attention at the early stages of the approach (Raskin, 1948; Patterson, 2000). The key characteristic of empathy is understanding another persons subjective reality as she experiences it at any given moment. This requires an orientation toward the clients' 'frame of reference', a phenomenological term used to describe the particular issues, concerns and values that are relevant to that individual in that moment. It is thus an attitude through which the therapist strives to "enter the client's private perceptual world and [become] thoroughly at home within in" (Rogers, 1980, p142). In other words, empathy is the experience of trying to fully understand another person's world.

In contrast to sympathy, which involves a *sharing* of outlook or experience, empathy requires a 'bracketing' (Cooper, 2004) or setting aside, by the practitioner, of own experiences, attitudes and ideas, with a focus, instead, on trying to understand how another person is feeling and thinking. From a therapists' point of view, an empathic attitude is a desire to understand a clients perceptual world as *if* it was his or her own (Rogers, 1959). The term 'as if' is important here, for it denotes that empathy is about deeply understanding a client's experiences while at the same time *not forgetting* that they reside within the client (Macmillan, 1997). This recognition allows a counsellor to maintain the separation between his or her own experiences and those of another

(Tolan, 2003), something which is of paramount importance to avoid confusion and misunderstanding.

### *Being empathic*

The most common method of experiencing empathy is to listen to closely to what a client is saying, not only through words, but also through all forms of non-verbal and bodily communication. For Brodley (2000, pp.18) the targets of empathic understanding are thus a “clients perceptions, reactions, and feelings, and the ways in which the client as a self or person is an agency, *an actor*, and active force – a source of actions and reactions”.

Empathic understanding is only effective in person-centred terms if is effectively communicated (condition 6) to a client, a process that ensures the client knows that the therapist understands how he feels as well as checks the extent to which the empathy expressed is accurate. There are a number of common mechanisms employed within person-centred therapy to achieve this. Perhaps the most familiar of these is reflecting back, or paraphrasing, a client’s personal experiencing (which can include, thoughts, feelings and, indeed, motivations for future actions; Bohart, 1997). In order to ensure accuracy, however, any kind of empathic statement has within it the implied question ‘is this how it is for you?’ (Barratt-Lennard, 1998). Indeed, Rogers steered away from the use of the term ‘reflection’ in relation to empathy, preferring instead phrases such ‘testing understandings’ or ‘checking perceptions’. These he argued, were more accurate descriptions of what was actually occurring in the moment by moment tracking of a client’s frame of reference at any given moment (Rogers, 1986).

#### **Box 2. Example of empathic reflection**

C: I have been having a dreadful time recently, what with all the disruption at home and work. It just seems as if things couldn’t get much worse.

T: So, it’s been a terrible both at home and at work. It seems to be coming at you from all sides. Things couldn’t get any more awful than they are at the moment?

C: Yes, I’m at my wits end (becoming tearful)

In this example, the client (C) describes a view of her situation, indicating that her recent “dreadful” time is linked to “disruption” at home and at work. Rather than ask for more details as to the nature of the disruption cited, or why it has had such an effect (as, perhaps, may be expected in normal conversation), the therapist (T) offers an *empathic*

*reflection* of the clients experiences. This allows the client to experience the therapist's understanding of her feelings ("I'm at my wits end"), a process which deepens the extent to which she contacts her organismic experiencing (i.e. the feelings that invoke tearfulness).

Despite the emphasis on reflection. Bozarth (1984) has suggested the attitudinal basis of empathy within the person-centred framework allows for a far greater range of empathic responses than often acknowledged. He argues that the person-centred therapist should actively strive to develop what he terms as *idiosyncratic* modes of empathy which are (op.cit, pp.75); "not standardised responses but idiosyncratic to the persons and interactions between the persons in therapy sessions. Such modes are learned by therapists as they are allowed to affirm their personal power as therapists...the equating of reflection with empathy has restricted the potency of therapists. The focus on empathy as a verbal clarification technique limits the intuitive functions of therapists"

In suggesting the empathic attitude is idiosyncratic, Bozarth makes it clear that therapists must learn to use their intuitive experiencing as part of the empathy process, and hence employ methods such as metaphors, similes, questions, silences and personal reflections to relate their understanding to the client. Such methods, which often may be experienced as risky for they do not offer a certain outcome (Bozarth, 2004), can evoke (Rice, 1974) an aspect of organismic experiencing not previously acknowledged. Indeed, for Cooper (2002) empathy is not simply a cognitive or affective process but also a bodily one involving physical sensations (such as feelings of nausea). Bodily sensations, when experienced by a therapist, may empathically resonate with a clients own bodily experiencing at a particular moment in time, thus providing an important vehicle for empathic understanding. Forms of physical posture and gesture that mimic, intentionally or otherwise, a client's bodily presentation may also be considered as inherent elements of a truly empathic relationship. Indeed, Cooper argues that there is much evidence to indicate such a mimetic process is, what he terms "an innate and instinctive human capability" (pp. 224). For the therapist, therefore, the issue is less of how to develop embodied methods of empathising and more as to how can such natural forms of relating be (op.cit., pp.224) "allowed to emerge" in the context of a therapeutic process.

### *The role of empathy in facilitating change*

When situated within a person-centred therapeutic relationship, empathy is seen by some to play a curative role (Warner, 1996) in facilitating psychological growth. For Rogers (1959), this role links primarily to the act of clarifying and checking (i.e. reflecting back), a process which encourages a client to enter more deeply into his or her personal experiencing. As the therapist attempts to understand the client's inner world, her empathic responses serve to assist the client to contact (Warner, 1996) organismic values, for example, to clarify the extent to which the therapist's description maps onto an aspect of organismic experiencing previously denied or distorted. As a result of this process, the client moves deeper into what is felt at an organismic level, perhaps for the first time recognising or conceptualising a particular experience (e.g. fear) that was not previously acknowledged within the self (i.e. something that I, as a person, feel). In doing this, she is potentially able to integrate these new felt experiences into her view of who she is (i.e. her self-concept). This process relieves the tension or anxiety produced by the incongruence between self and organismic experience, thus facilitating psychological change.

Over the years, many theorists have attempted to explicate in greater detail the role and nature of empathy as part of the therapeutic endeavour (Wilkins, 2003). Vanerschot (1993) has attempted to draw together a number of strands of such work in proposing a framework for understanding how empathy works to produce a number of *micro-processes* in the client. For Vanerschot, empathy works in three ways. Firstly, an empathic climate created by a therapist serves to foster self-acceptance and trust by the client through the experience of being understood and accepted by another. This works to counteract her lack of positive self-regard. Secondly, as discussed previously, the concrete empathic responses (e.g. reflecting a feeling) made by a therapist serve to enhance and facilitate a client's experiencing, by assisting her to move further into his organismic experiencing. Such responses may relate to aspects of a client's experience that are at the very edge (Gendlin, 1981) of her conscious awareness (i.e. poorly denied or distorted) and hence involve the therapist using responses such as exploratory questions (e.g. "I wonder if there is something else other than anger in how you feel at the moment"), empathic guesses ("I guess you must feel pretty sad that she has left



you”) and experiential responses (e.g. “ I don’t know why but I feel very tearful when you speak about your father”). Such responses are often termed ‘deep’ or ‘advanced’ empathy (Mearns and Thorne, 1988) to denote the way that they relate to an aspect of the client’s experiencing that is not directly being addressed or acknowledged until that point.

Finally, all empathic responses to a client have a cognitive effect, assisting the client to also re-organise the meanings of the experiences being processed. This is the third element identified by Vanershot (1983), and is a product of assisting the client to focus his or her attention on particular experiences, to recall information relating to an experience or to organise information in a more differentiated and elaborative manner. From such a perspective, the therapist may be seen as, what Wexler (1974) suggests as a ‘surrogate information processor’, whose empathic responses facilitate a process of cognitive re-organisation and re-structuring.

### **Unconditional positive regard**

Although empathy is seen by many as the primary, change-related dimension of person-centred therapy, unconditional positive regard has also been proposed by some (e.g. Bozarth, 1998, Wilkins, 2000) as the fundamental element of the relationship specified by Rogers (1957). In contrast to the long history enjoyed by empathy as part of Rogers’ approach, the *concept* of unconditional positive regard did not emerge until the mid-late 1950’s, having previously been referred to as acceptance, warmth, prizing and respect (Bozath, 2002). Indeed, the terms are still often used interchangeably, although for some (e.g. Purton, 1998) the differences in meaning between them introduces a conceptual confusion regarding what each actually involves.

For the majority of person-centred practitioners, unconditional positive regard, along with the various terms equated with it, simply refers to the experiencing and offering of a consistently accepting, non-judgemental and valuing attitude toward a client (Lietaer, 1984). For Brazier (1993) this may best be considered as a form of non-possessive ‘love’, a warm acceptance the client as he is in any given moment, not judging, instructing or neglecting. The term ‘unconditional’ is thus used to denote this quality – nothing is required of a client for her to be viewed in a *positively regarding* manner.

### *Offering unconditional positive regard*

Unconditional positive regard is perhaps the most challenging of all the conditions to experience and thus to offer. Indeed, in discussing how to accomplish this, the majority of training materials (e.g. Tolan, 2003) concentrate on what it is *not* unconditional positive regard, rather than what it is! Despite this, offering unconditional positive regard often relies on listening and responding non-judgementally to whatever a client is experiencing at a given moment. Although this may imply a passive quality, unconditional positive regard is more active, openly warm, valuing process. Indeed, Freier (2001) argues that the term *positive* is used deliberately to indicate the warm nature of the experience, rather than a cold form of passive acceptance indicating 'neutral passivity'. What this means, in practice, is that in offering unconditional positive regard, the counsellor actively strives to warmly value the client in all aspects of his or her experiencing. As Brodley and Schneider (2001, pp.156) suggest;

“ Client-centred therapists consciously cultivate a capacity for unconditional acceptance towards clients regardless of the client’s values, desires and behaviours. The UPR capacity involves the ability to maintain a warm, caring, compassionate attitude and to experience those feelings toward a client regardless of their flaws, crimes or moral differences from oneself”

#### **Box 3. Is *unconditional positive regard* possible?**

The idea of unconditional positive regard has been strongly criticised by various theorists (e.g. Masson, 1992) who argue out that it requires a therapist to withhold any moral judgements on another individual’s actions. This, they suggest is impossible as well as politically unacceptable. Certain forms of behaving (e.g. violence toward others) are wrong and should not be accepted. As someone’s ‘self’ cannot be separated from her ‘behaviour’ (Purton, 1998), it is not possible to offer unconditional positive to an individual’s inner experiences, whilst not condoning what they do. Hence, as Seager (2003, p.401) proposes, “unconditional positive regard is impossible in any human relationship”.

For person-centred practitioners, such a view of unconditional positive regard fails to recognise a number of important aspects regarding its place within the person-centred therapy. Firstly, as with all the core conditions, it is not an experience that a therapist is viewed as able to have *all the time* when relating to a particular client. This misapprehension is perhaps a product of its name, which has an absolute, *either or* quality that does not reflect the flowing process of any relationship within which the

conditions are upheld to different extents at different times (Rogers, 1957). Secondly, no act or experience is *inherently unacceptable*, and a therapist's capacity to offer unconditional positive regard is a product of his social, cultural and individual values. Thus the experiencing of unconditional positive regard is linked to a therapist's own moral standpoints. It is also enmeshed with the level of his own self-acceptance, for our capacity to unconditionally value another stems from our capacity to *understand*, and *accept*, ourselves in all of our flaws (Mearns and Thorne, 1988). Such understanding and self-acceptance enables us to experience a client in a non-defensive manner, and hence to look behind (Wilkins, 2000) an unacceptable behaviour or attribute to understand the psychological suffering or pain underlying it. Of course there are occasions in therapeutic relationships when this is not possible, for example, when a particular client is encountered that presents a particularly powerful challenge to the moral stance we uphold. For Wilkins (2000), within such circumstances we are able to recognise our limitations, which in turn allows us to find the most appropriate way of enabling that client to be transferred to a different therapist who, as a result of his or her own unique personality, may view the situation differently, or indeed may have the capacity to offer a greater level of unconditional positive regard. Thus, from such a standpoint, unconditional positive regard is not impossible, but dependent upon the match between therapist and client.

#### *The role of unconditional positive regard in facilitating therapeutic change*

Unconditional positive regard works, as part of the therapeutic relationship, by diminishing conditions of worth which are at the root of the incongruence between organismic experience and the self. As conditions of worth are acquired through a *conditionally valuing* relationship, unconditional positive regard is seen to stimulate the exact opposite, a climate of unconditional acceptance and warmth. It is the very *unconditionality* of this climate that promotes growth, for it enables the processes of psychological defence to be reversed. This reversal is simply a product of the degree of threat presented by conditions of worth being gradually eroded by the presence of an unconditionally warm and accepting other (Rogers, 1959).

The role of unconditional positive regard is enmeshed with the processes of empathy. In contacting denied or distorted organismic experiencing that is then unconditionally accepted and valued by a therapist who is empathically attuned, the client is able to feel fully accepted and thus develop a greater sense of positive self-regard. As Lietaer suggests (2001, p.105), unconditional positive regard thus produces "a high level of safety which helps unfreeze blocked areas of experience and to allow painful emotions in a climate of holding...self-acceptance, self-empathy and self-love are fostered". When these are empathically received, the client is able to re-configure his or her self-concept

to encompass greater levels of organismic experiencing, thus reducing the incongruence at the root of her distress.

## **Congruence**

Like unconditional positive regard, the *concept* of congruence emerged in the 1950's and was first introduced in Rogers' personality theory (1951) to denote the state in which the self and organismic experiencing are aligned (i.e. the opposite of *incongruence*). It was subsequently identified of relevance to therapy within Rogers (1957) theory of the necessary and sufficient conditions of therapy. Congruence, as part of these conditions, is formulated as a state of being (Wilkins, required of the *therapist* within the counselling relationship (i.e. 'the second person, whom we shall term the therapist, is *congruent* or integrated in the relationship" Rogers, 1957). By contrast, the client within such a relationship is *incongruent* ('the client, is in a state of incongruence, being vulnerable or anxious', (Rogers, 1957). He thus defined congruence in therapy as meaning;

"that the therapist is his actual self during his encounter with his client. Without facade, he openly has the feelings and attitudes that are flowing in him at the moment. This involves self-awareness; that is, the therapist's feelings are available to him – to his awareness – and he is able to live them, to experience them, in the relationship, and to communicate them if they persist" (Rogers, 1966, p.185).

Congruence thus refers to the therapist's capacity to be aware of the full extent of her own organismic experiencing (unlike the client who is still *incongruent*). Although the term congruence was used interchangeably with other adjectives such as authentic and genuine, Rogers regarded the requirement for the therapist to be attuned to actual self as the most fundamental of all the three core conditions (Rogers and Sanford, 1984). He saw no role for professional façade nor the impersonal relating often associated with a lack of self-development (or incongruence) on behalf of the therapist.

### *Being congruent*

The condition of therapist congruence is the least understood of all the core conditions and has been open to considerable misunderstanding and misinterpretation over the years (Wyatt, 2001). Although the meaning of congruence is not in doubt, being a state where a therapist is not subject to incongruence between self and organismic experiencing, there are a number of areas of debate surrounding what this actually involves in terms of therapeutic practice. Perhaps the most controversial of these is the extent to which a therapist communicates his or her inner organismic experiencing (e.g. feelings of anger, or sadness) to her client. This controversy stems right back to the work of Rogers, who viewed the expression of genuine feelings as part and parcel of *being* congruent within a therapeutic relationship (Rogers 1959). Yet, for Lietaer (1993), a therapist's inner awareness of her ongoing experiencing must be differentiated from the outer expression of this experiencing. For him, these are two different things, and only when taken *together* represent the therapists genuineness (or congruence) in the relationship. From such a standpoint, the congruent practitioner must be aware of these different elements and attend to each within the therapeutic encounter.

One of the key issues arising from the distinction between an awareness of organismic experiencing (e.g. feeling sad) and the expression of such experiencing is an important one, how each relates to the other, particularly in terms of what inner experiences to disclose, and how (e.g. Tudor and Worrall, 1994, Barratt-Lennard, 1998). It is one thing for a therapist to recognise and acknowledge within herself a particular experience with a client (e.g. "Gosh, I feel so sad when she talks about her Mother"). It is a very different matter to determine when and how to express this experience to that client. Certainly, in discussing the expression of therapists feelings and experiences in therapy with a client, Rogers (1966, p. 185) urged caution;

"[congruence] does not mean that the therapist burdens his client with the overt expression of all his feelings, Nor does it mean that the therapist discloses his total self to the client. It does mean, however, that the therapist denies to himself none of the feelings he is experiencing and that he is willing to experience, transparently, any persistent feelings that exist in the relationship and to let these be known to the client. It means avoiding the temptation to present a façade or hide behind a mask of professionalism, or to assume a confessional-professional attitude"

For Rogers, it is only *persistent* inner experiences that should be expressed to a client, nothing else. Such feelings may be either positive or negative, although both can be of vital importance in supporting the other core conditions (empathy and unconditional positive regard). For Rogers, it was far more important to admit to feeling, say, bored or frustrated, than attempt to *pretend* to a client that everything was OK.

Although the cautious expression of persistent personal feelings within a therapeutic relationship is advocated by the condition of congruence, this aspect of the approach presents a significant challenge to other therapeutic models in the counselling psychology or therapeutic field (Greenberg and Geller, 2001). Certainly the idea that professional psychologists or therapists express how they *personally feel* at times can seem a highly threatening prospect, particularly if it involves the admission of feelings that may imply weakness, confusion or vulnerability. These can seem so different to distant, objective perspective that is often a part of a professional psychological activity. It can also open a psychologist up to charges of over-involvement and, potential inappropriateness.

Much concern over the potential expression of personal experiencing advocated by the condition of congruence stems from the way in which the disclosure of feelings by a therapist is often associated with an undisciplined process that Haugh (2001) calls the 'I felt it so I said it' syndrome. Yet, a therapist simply stating what he feels at any indiscriminate moment in time is certainly *not* what a person-centred approach advocates, and a general rule of thumb in psychological therapy generally would be that saying less (not more) is to be valued.

### *The role of congruence in facilitating therapeutic change*

For Rogers, congruence was the most important therapist conditions due to the way that it *underpins* the experiencing of unconditional positive regard and empathy. Without congruent awareness of his own organismic experiencing, it is highly likely that a therapist's own experiences in relation to a client will be influenced his own incongruence, and thus conditions of worth. This will inhibit his experiencing and communication of both empathy and unconditional positive regard in ways such as, a) his failure to recognise (and thus empathise with) a personally denied emotion that is

being expressed by a client, b) his reaction (e.g. anger) to a client which is distorted into another feeling (such as excitement), and c) his judgemental feelings about aspects of a client's experiences (such as racist assumptions) due to his own conditions of worth regarding race.

By not being fully aware of his own organismic experiencing, the incongruent counsellor potentially makes life very difficult for herself and her client. This, for Mearns and Thorne (1988), highlights the importance of counsellor self-acceptance, for the more fully a practitioner can accept himself, the fewer conditions of worth that will inhibit the empathy and conditional positive regard he experiences in relation to his clients. Certainly, a counsellor who is highly congruent and self-accepting appears to practice what she preaches and her words and actions match up. Incongruence (or a lack of self-acceptance) has a different flavour, often manifesting in an inconsistency between what is being said and what is being expressed in other ways (e.g. tone, gesture, posture etc.). The reason for this is that the counsellor is, essentially, not fully aware of some of her own reactions (e.g. anger) which are being felt at an organismic level. These reactions cannot necessarily be hidden from others can therefore be seen in unanticipated ways (Grafanaki, 2001) indicating, directly or otherwise to the client, that what is being said is not the whole picture. Such inconsistencies can have a considerable impact on a client's trust for the counsellor, potentially inhibiting a clients' preparedness to experience her therapist's empathy and unconditional positive regard as fully as she may. In such circumstances the counsellor may not be seen as sufficiently trustworthy for her empathy and unconditional positive regard to be received.

### **The core conditions as a single condition?**

Although it is possible to examine each of the core conditions in terms of their unique contribution to the process of person-centred therapy, it is misleading to consider any one of these as distinct from each of the others (Merry, 2004). The roles of empathy, congruence and unconditional positive regard are entirely interlinked within person-centred therapy, each supporting the others to invoke the climate of safety and understanding that is pivotal to reducing client incongruence. They make up part of a system that, from this perspective, is so interdependent it may better be considered as *one single condition* in itself. Certainly for Mearns and Cooper (2005), it is the

*combination* of empathy, unconditional positive regard and congruence that allows a therapist to experience what they term 'relational depth' when with a client. This they describe as (op. cit., pp.36);

"A feeling of profound contact and engagement with a client, in which one simultaneously experiences high and consistent levels of empathy and acceptance toward that Other, and relates to them in a highly transparent way. In this relationship, the client is experienced as acknowledging one's empathy, acceptance and congruence – either implicitly or explicitly – and is experienced as fully congruent in that moment"

Although, from such a perspective, it is possible to break down the experience of relational depth into the component parts of empathy, unconditional positive regard and congruence, Mearns and Cooper argue that these are in fact "facets of a single variable: relational depth" (op.cit, pp.36), rather than discrete variables in themselves. As a result, they emphasise the power of the core conditions as something that arises from the *integration* of these qualities into a particular way of being, rather than viewing each as something that may be assured independently of the others.

Despite the importance of the core conditions in the person-centred approach to therapy, it is also important to remember that three further attributes were also specified by Rogers (1957) as 'necessary and sufficient' for change to occur. These will be explored in the following section.

### **The conditions of psychological contact, client incongruence and therapist communication**

As well as the conditions of empathy, congruence and unconditional positive regard, Rogers (1957) proposed that psychological change within the client was dependent upon, a) psychological contact between counsellor and client being established, b) the client being incongruent and experiencing anxiety or vulnerability and, c) the successful communication, even to a minimal degree, of the therapist's empathy and unconditional positive regard. Although these conditions are less concerned with the actions and attitudes of the therapist, they are instrumental in the *relationship* that is enacted between client and counsellor, and therefore of paramount importance in the therapeutic



work undertaken. They are often termed the 'relationship conditions' (Sanders and Wyatt, 2002) because they refer to the *minimal requirements* any therapeutic relationship must meet in order for psychological change to occur (assuming the core conditions are also present).

**Box. 4 The case of the 'lost' conditions**

Have three of the six conditions for therapy specified by Rogers been lost? Keith Tudor (2000) certainly thinks so. He argues that the way in which the person-centred theory of therapy is so often associated with the three *core* conditions is become a major problem for the approach, and part of the reason why the strong psychological basis of the theory is often neglected. He goes on to propose that the loss of the *non-core* conditions has led to a significant dumbing down (2000, p.35) of the theory itself. Certainly, Rogers never termed any of the six conditions *core* nor specified that any was more important than others (as implied by the term *core* itself!). Such a view distorts the way in which each of the six conditions are essential for therapeutic change to occur, as well as the extent to which person-centred theory of therapy involves far more than simply a description of therapist's actions or attitudes.

*Psychological contact*

The first condition of therapy as defined by Rogers (1957) is that *two persons are in psychological contact*. For Rogers, this condition stipulated that an acknowledged *interaction* was required for successful therapy to take place. Certain aspects of contact were thus necessary, such as basic attentional and perceptual functioning, and the capacity to communicate with, as well as perceive, another person. Unless this pre-condition (Rogers, 1957) is met, and this is by no means guarantee, none of the other conditions can be fulfilled. Therapy, as a result, will most probably be ineffective.

On the basis of its apparent obviousness, psychological contact was, for many years, generally *assumed* within person-centred practice. Hence this condition became seen as the 'backing vocals' to the core conditions offered by the therapist (Sanders and Wyatt, 2002). However, theoretical work by person-centred practitioners such as Prouty et al. (2002) have highlighted a number of reasons why psychological contact *cannot* always be assumed. For example, highly disturbed clients with (psychotic) delusional experiencing or those with low-level functioning (e.g. people with advanced dementia) are often unable to establish full, relational contact with another person in a consistent manner. As a result, psychological contact is now often seen, not a dichotomous

construct (i.e. being either present or not present – as implied by the wording of Rogers' condition 1), but as one that can *vary* in accordance with a clients level of psychological disturbance and cognitive functioning (Mearns, 1997).

Although some clients, by virtue of their disturbed psychological state, are what Prouty and Van Werde (2002) term 'contact-impaired' to the extent that they are unable to engage in *any* therapeutic relationship (and thus require a process what he terms 'pre-therapy'), others are more able to minimally establish contact with a therapist and vice versa. Such individuals often have considerable levels of incongruence and are liable to rigid processes of denial and distortion. Hence, psychological contact is often limited and therapy subject to considerable fluctuation in the degree to which contact is present or otherwise. The issue of psychological contact is an important area of work within the person-centred framework, and provides a framework allowing many of the severe psychological disturbances commonly associated with psychiatric (i.e. medical) definitions, such as personality disorders and psychoses, to be understood and addressed from a person-centred perspective. These will be explored in more depth in chapter 5.

#### *Condition 6 - Communication*

Condition 6 is often seen as the other side of the requirement to establish psychological contact. This condition, in its original wording (Rogers, 1957) states that, 'the communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree, achieved'. Thus it is the client's capacity to *perceive* the communication of the therapist's empathy and unconditional positive regard that is stressed as also a necessity for therapeutic change to occur. Hence, as well as basic contact, the client must be able to experience the therapist's empathy and unconditional positive regard.

Although the term 'minimally achieved' indicates that these qualities do not have to be perceived in significant terms (irrespective of the extent to which they are communicated by the therapist), the requirement is that they must be experienced to *some extent* as part of the therapeutic endeavour for psychological change to occur. For clients unable to establish *any* degree of psychological contact with a therapist, experiencing the

counsellor's empathy and unconditional positive regard will be impossible and effective therapy is thus highly unlikely. Similarly, clients whose level of disturbance is high or cognitive functioning low will experience only minimal levels of the therapist's empathy and unconditional positive regard. In such circumstance it is probable that change will be slow and difficult.

### *Client incongruence*

As well as stipulating that the therapist must be 'congruent or integrated' in the relationship, Rogers (1957) added a second criterion, condition 2, linked to the notion of incongruence. This states that 'the client is in a state of incongruence, being vulnerable or anxious', a condition which thus makes it necessary for the client to have a *need* for change, a need emerging from the uncomfortable experience of the vulnerability or anxiety (these are catch-all terms used to denote the experience of psychological distress) produced by incongruence. The notion of need is important, for the condition implies that, as a result of the experience of vulnerability or anxiety, the client, is *aware* that he or she is encountering difficulties (Singh and Tudor, 1997). Embleton-Tudor et al. (2004) go on to argue that such awareness is, in essence, a self-identified sense of something being wrong which serves to motivate a decision to seek help. Hence, the condition may be seen as stipulating a client's *willingness* or *consent* to engage in the counselling process.

Of course there are situations where people are 'sent' to see a therapist, perhaps by an employer or within the justice system. However, if the client in such circumstances does not experience themselves as anxious or vulnerable (such as in instances where the process of denial and distortion are working effectively to maintain the self-concept as it is) person-centred therapy is not guaranteed to produce change. A similar outcome is likely in individuals who are not significantly incongruent, and thus not anxious or vulnerable. Such individuals are seen to have sufficient positive *self-regard* and thus have no requirement (at that moment) for a therapist's empathy or unconditional positive regard. Although a therapeutic relationship may be helpful in talking through issues or concerns, further change is not certainly inevitable even if, indeed, it is possible.

## **Ways of person-centred working**

In simply describing six 'necessary and sufficient' conditions for psychological change to occur, Rogers provided much potential for variability in how these processes would be enacted within the therapeutic context. As such, differences in therapeutic standpoint and practice were implicit within his original theory (which, in its 1957 presentation, was an integrative statement relevant to all forms of psychological intervention), seen as something to be expected and celebrated rather than discouraged. Indeed, Rogers disliked the idea of the approach standing still, and was a strong advocate of innovation and change. Since the first presentation of theory of therapy, a number of different approaches to person-centred working have evolved, each taking a somewhat different slant on how best to facilitate change within a client. Although these generally share the underlying assumptions of the original theory, for Warner (1999), there are now a number of different 'tribes' of the 'person-centred nation' that offers something different in terms of method of person-centred working.

One way of considering such 'tribes', as we explored in chapter 1, is in terms of a general distinction between 'classical' and 'experiential' approaches. Hence we shall briefly explore each of these domains as a means of briefly mapping the key contemporary ways of working within person-centred therapy.

### *The Classical Approach*

One of the most common way of working amongst person-centred practitioners, particularly in the UK, is to employ a 'classical' approach which adheres to the terms of client-centred therapy detailed by Rogers in his papers published in 1957 and 1959. It is this 'classical' way of working that is detailed in the majority of skills development and practical texts associated with the a 'person-centred' approach to therapy. Merry (2004, p.43) proposes that a 'classical' approach to person-centred therapy has four central principles. In summary, these are;

1. A sole emphasis on the theory of actualisation as the motivation for growth;
2. A therapists role as entirely that of a non-judgemental, empathic companion offering unconditional positive regard;

3. The therapist achieving a sufficiently high level of personal congruence to enable her to be fully self-aware and thus genuine;
4. The therapist fully trusting the client and thus maintaining a non-directive attitude in terms of the content and process of therapy,

Although each of these principles are significance, perhaps the most important element of 'classical' person-centred therapy, or at least the one that differentiates it from 'experiential' ways of working, is its fundamental emphasis on *non-directivity* on behalf of the therapist (Levitt, 2005). Classical person-centred therapy resists any form of direction in terms of both content (e.g. suggesting a topic to talk about) or process (e.g. suggesting a focus on a particular aspect of experiencing). The client is fully trusted in his or her capacity for change (due to the presence of the actualising tendency, which is seen to motivate change when enabled to do so) and the role of the therapist is thus seen entirely as one of an empathic, non-judgemental companion. In essence then, the six conditions discussed previously remain both necessary *and* sufficient for change to occur.

### *Experiential approaches*

There are a variety of different ideas and methods within the 'experiential', framework all of which share the same goal of classical person-centred therapy, namely to facilitate the client's processing of organismic experiencing and thus to reduce incongruence. Where these differ to 'classical' person-centred therapy is the way in which this goal is enacted, or as Lietaer (2002, pp.1) states, the difference "is to do with *how* a therapist tries to facilitate experiential self-exploration". For 'experiential' practitioners, various strategies and techniques may be employed to assist a client contact (and process) previously denied and distorted organismic experiencing. Such strategies and techniques require a more active therapeutic stance, and therefore the therapist guides a client toward his organismic experiencing in particular ways. Hence she sometimes 'directs' the therapeutic work, and in doing so, adopts a position of 'process-expert' in identifying an aspect of the client's experiential processing that may be assisted by a specific strategy or technique (Worsley, 2002). Although the relationship remains central in facilitating change, it is therefore not necessarily viewed as sufficient in itself. It is

these aspects that differentiates experiential was of working from classical person-centred therapy (Baker, 2004).

### *Eugene Gendlin and Focusing*

Without a doubt, the work of Eugene Gendlin has been hugely significant in the development of an experiential 'tribe' (Warner, 1999) within the person-centred framework. Gendlin was a philosophy student who, in 1953, became a colleague of Rogers at the University of Chicago with an interest in finding ways of assisting people to engage more fully with their own experiencing. Over time, he subsequently evolved a method of working with what he termed the 'felt sense' (Gendlin, 1978), devising a method, called *focusing*, as a means of contacting organismic experiencing at the 'edge' of conscious awareness' (Gendlin, 1978). Such experiencing was then allowed to 'unfold' from being simply a felt sense of *something* (Gendlin, 1997) to a more concrete, conceptualisation of an experience or situation (e.g. the conscious acknowledgement of an organismic feeling of 'anger'). The process of focusing allows for psychological growth and a reduction of incongruence, as previously denied or distorted experiencing is conceptualised and integrated into awareness.

Although Gendlin's ideas have a complex philosophical slant, he provides a very straightforward method designed to aid the client to 'focus' on his own experiencing. This procedure (Gendlin, 1996) is taught to the client by the therapist and has six steps which include, a) clearing a 'space' (i.e. bringing attention to the bodily area in which we feel our emotions), b) identifying a 'felt-sense' in that moment, c) finding a handle for that sense (i.e. matching the physical felt quality with a way of representing it to ourselves) and, d) moving back and forth between handle and felt sense, noticing any shifts in either. Although this process has many technical aspects to it, in common with the 'classical' person-centred approach, Gendlin views the therapeutic relationship as of utmost importance in enabling a client to feel understood and valued in her experiencing. Moreover, the focusing procedure is client-directed in terms of content and always ever only *offered* as a possible method of working. It may therefore be seen to accord strongly with the fundamental respect outlined by Rogers as integral to a non-directive attitude (Purton, 2004b). However, unlike more 'classical' work, focusing involves the active 'direction' of a client toward felt aspects of his or her experiencing in accordance

with the method outlined. Hence, the client is sometimes *not trusted* to determine how best to attend to and manage her experiences within the therapeutic encounter (and accordingly provided with techniques and methods for doing so), thus comprising the intention of the six conditions specified by Rogers (1959) as *necessary and sufficient* for change to occur. Indeed, focusing is now only one of a wide range of other techniques to facilitate experiencing by the client used by practitioners following Gendlin's ideas (c.f. Purton, 2004a).

<b>Box 5. Key Differences between Classical and Experiential Approaches</b>	
<p><i>Classical</i></p> <p>Six conditions of therapy seen as necessary and sufficient at all times</p> <p>Avoiding all direction of client's experiences or focus in therapy.</p> <p>No additional therapeutic techniques utilised or taught to the client</p>	<p><i>Process-experiential</i></p> <p>Six conditions of therapy seen as necessary but not always sufficient</p> <p>Suggesting methods to help experiencing but <i>not</i> directing content of client's experiencing (i.e. through interpretations)</p> <p>Use of specific techniques to aid client contact organismic experiencing. Some techniques taught to the client</p>

### *David Rennie's Experiential Approach*

A psychologist who has done much to forge a middle ground between the work of Gendlin and that of Rogers is David Rennie, whose book *Person-Centred Counselling: an experiential approach* (Rennie, 1998) describes a method of working that highlights the role of reflexivity in the therapeutic endeavour. Reflexivity refers to the way that we are able to reflect on (i.e. be reflexive) our experiencing, as well as experience it, something Rennie feels is ignored by Rogers in his primary emphasis on empathising with a client's *experiencing* in here and now. He argues reflexivity plays an important role in therapy for it allows the therapist to draw the client's attention to aspects of her experiencing of which she may not be consciously aware, and to enable reflection on these as part of the therapeutic process. Examples of such aspects may include, for example, ways in which the client uses language (e.g. common metaphors or words),

aspects of non-verbal communication (e.g. clenched fists), aspects of 'meta-communication' (i.e. communication about communication) between client and therapist (e.g. the way a client implies to the therapist that he isn't good enough for her'). Rennie argues that a key role of the therapist is to 'direct' a client's attention to such aspects. In doing so, he views the reflection process itself as invoking further experiencing (e.g. recognising sadness being expressed non-verbally leading to consciously experiencing that sadness) thus invoking psychological change.

Like Gendlin, Rennie (1998) views the role of therapist as going beyond that envisaged by 'classical' practitioners. In suggesting that the counsellor 'direct' the client toward particular aspects of her experiencing, he proposes therapists must assume the role of 'expert' at certain times in the therapy (e.g. by offering comments, observations and suggestions based). Indeed, Rennie embraces this opportunity, arguing that such a role allows the therapist to 'model' to the client the capacity to make choices as an agential being (i.e. having agency to decide how to act, rather than 'being determined' and fixed). This, he sees, as vital to the therapeutic task. Many clients, he argues, do not see themselves as having choices and thus often need "some help in dealing with themselves" (1998, pp.81). One form of assistance is to highlight the client's capacity for agency in all circumstances.

### *The Process-Experiential Approach*

By far the most controversial of all experiential approaches is that associated with the work of Leslie Greenberg, Laura Rice and Robert Elliot (e.g. Greenberg et al., 1993). Indeed, there is a very big question over the extent to which work this may be considered *person-centred* at all, for it does not share many of the ideas expressed by Rogers with regard to the nature and basis of personality change (Baker, 2004) and takes a highly technical stance on the therapeutic process thus diminishing the significance of the therapeutic relationship itself in facilitating change.

Greenberg et. al. (op. cit), whose approach is now often known as Emotion-Focused Therapy, propose a complex theory of emotional processing (their focus is very much on emotion), arguing that we develop 'emotion schemes' throughout life that often do not match up to how we cognitively assess particular situations. So, for example, we may



know we are safe in the dark, but still feel fear when the lights go out. This cause of such discrepancies they argue, are emotion schemes that are either maladaptive (i.e. no longer suitable for the situations being encountered) or those orientated around emotional experiences that were not processed fully or correctly when first formed. They identify a variety of formal techniques associated with making conscious the emotion schemes employed by a client, and where necessary, for re-processing the emotional experiences that originally gave rise to them. These techniques are arranged in relation to particular 'markers' linked to certain types of internal processes within the client. So, certain types of techniques are used in certain situations, such as 'two-chair' work (i.e. the client talking from two different two chairs alternatively, each representing a different 'part' of their self) when a client encounters internal conflict etc. The envisaged outcome of their work is what they term, the increased *mastery* (Greenberg et. al, 1993) by a client over her emotional experiencing.

The work of Greenberg et. al. has much in common with person-centred ideas on the role of incongruence in psychological disturbance (i.e. emotions often being unavailable to conscious awareness), and also highlights the significance of an empathic, non-judgemental relationship between therapist and client in the change process. However, it is certainly at the furthest edge of person-centred work and may thus be seen as simply informing experiential approaches to person-centred therapy, rather than as a specific method or form of person-centred working in itself.

#### *New Approaches – Dialogical Person-Centred Therapy*

Although both 'classical' and 'experiential' approaches have evolved over what is, by now, a significant period of time, in recent years a new perspective on person-centred therapy has developed highlighting the importance of *relationship* at the core of the therapeutic encounter. However, unlike 'classical' or 'experiential' approaches to person-centred therapy, which give primacy to the *therapist's* contribution and role within the therapy (e.g. in terms of 'attitudes' or 'techniques'; Sanders, 2004), a relational (often termed 'relational' or 'intersubjective') approach highlights the relationship that is created between client and counsellor, viewing this as a *co-created dialogue between two persons* rather than a series of therapeutic attributes offered to one by another (Barratt-Lennard, 2005). Hence it is not primarily concerned with maintaining a non-

directional attitude (as in the 'classical' approach) or in facilitating change (as in the 'experiential' tradition), but instead with encountering the client in a deep, mutually experienced, way (Mearns and Cooper, 2005)

Prominent in developing this new perspective is Peter Schmid (e.g. Schmid, 2001), who argues that the fundamental basis of person-centred therapy is a dialogical encounter in which the differences between two human beings (i.e. therapist and client) provide the basis for deep, meaningful connection between them. From this, he argues, something new can emerge (Schmid 2001) as a result of the healing qualities of such an intimate, human-to-human experience (the lack of which, or its over-provision, is seen as the cause of all psychological distress).

The role of deep, interpersonal connection in therapeutic encounters is also highlighted by concept of 'relational depth' (Mearns, 1997; Cooper and Mearns, 2005). As we discussed previously, this is a process involving the full *integration* of the core conditions into a mode of relating that offers the possibility of a meeting where (Cooper and Mearns, pp.37) "two people come together in a wholly genuine, open and engaged way" without psychological masks, roles or safety screens. To encounter a client at relational depth provides that individual with an experience of truly meeting another human being who is empathic, accepting and affirming in their 'presence' (Rogers, 1980), and one who is thus able to provide a depth of interpersonal connection that enables psychological healing to occur. Although this is, essentially, the same process as one defined by Rogers (i.e. the relationship itself providing a climate in which the actualising tendency enables growth to take place), it is one that emphasises to a far greater degree the importance of the *interpersonal connection* over its constituent parts (e.g. the counsellors empathy). Such a connection can only ever be *co-created*, and thus is inherently dialogical (i.e. between two persons) in form and content. Yet, facilitating such a meeting is no easy task. For Mearns and Cooper (2005, pp.113-135), some ways that practitioner may attempt to do so are as follows;

- Letting go of 'aims' and 'lusts' – allowing preconceived desires or intentions for the client to dissolve prior to the therapeutic encounter;
- Letting go of 'anticipations' – avoiding all expectations and assumptions about the client;

- Letting go of techniques – avoiding using techniques or methods, which may block the possibility deep inter-personal relating;
- Listening, listening, listening – truly attending to what the client has to say at all levels of her being;
- Knocking on the door – inviting exploration of a client’s lived experiencing;
- An openness to being affected by the client - a preparedness to be influenced by deep contact with another person;
- Minimising distractions – taking practical steps to ensure that the meeting is the primary concern, rather than the gas bill!
- Transparency – a preparedness to be open and honest about personal feelings, vulnerabilities and experiences, as well disclosing confusions and uncertainties about the therapeutic process itself;
- Working in the here and now – remaining present focused, and indeed using the therapeutic relationship to explore the processes potentially preventing the client from being intimate with others.

Although many of these may seem somewhat ‘technical’ in form, their intention is to facilitate something almost completely opposite, namely a deep, connected, person-to-person encounter of the kind rarely found within the psychological domain. It is this intent that, once again, demonstrates the unique place of a person-centred approach within the counselling psychology arena.

<b>Summary</b>
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| <ul style="list-style-type: none"> <li>• The person-centred theory of therapy was formally outlined in detail by Carl Roger’s in 1957, although had been an integral part of his work until that point.</li> <li>• Roger’s argued that 6 conditions, if present within any therapeutic relationship were <i>necessary and sufficient</i> to induce psychological change within a client.</li> <li>• The 3 conditions linked to the activities of the therapist have become known as the core conditions. These are the experience of empathy and unconditional positive regard for the client, and the therapist being congruent in his or her own experiencing.</li> <li>• Empathy is an attitude of understanding for a client’s own experiencing or subject ‘frame of reference’ at any given moment.</li> <li>• Unconditional positive regard is an experience of non-judgemental value for the client.</li> <li>• Congruence is a state of being in which the therapist is not subject to incongruent experiencing produced by conditions of worth. It is associated with high levels of self-acceptance.</li> </ul> |
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- 3 further conditions specified by Rogers linked to the potential for therapeutic relationship. These were psychological contact being established, the client being incongruent and the therapist's empathy and unconditional positive regard being perceived by the client.
- There are various ways of working within person-centred therapy. Classical practitioners follow the therapeutic processes outlined by Rogers, viewing the six conditions as necessary and sufficient.
- Experiential practitioners view the six conditions as necessary but not always sufficient. They use different techniques or strategies to assist the client contact her organismic experiencing.
- In recent years a new, 'dialogical' approach to person-centred therapy has emerged emphasising the importance of deep, person-to-person encounters that are co-created by counsellor and client.