

## Whose problem is it?

### slide 1

In this next hour I will talk to you about an aspect of person-centred theory and therapeutic practice that has interested me ever since I started my work as a person-centred therapist.

It is my intention to share with you some of my thoughts, ideas and experiences– and I hope that my reflections may have some meaning for you, that they may stimulate you in your own thinking about your work and that they may have some relevance for your therapeutic practice.

Why did I choose this topic? I have a number of reasons.

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The **first reason** is personal: I have a longstanding interest in how we, as person-centred therapists, can develop an understanding of people (clients) who experience psychological disturbance or mental ill-health, who are diagnosed as mentally ill, depressed, psychotic, personality disordered, to name but a few of these frequently used labels. As a young clinical psychologist I was delighted to get my first job in a large mental hospital, where I chose to work in one of the wards that housed chronic psychotic patients. I was fresh out of University, inspired by my discovery of phenomenology and just beginning to learn about client-centred therapy. I was enthusiastic about the ideas of the anti-psychiatry movement and the potential of therapeutic communities. I remember vividly some of the people I met on my visits to the ward– the young man sitting in the corner, talking to himself incessantly and with great intensity, but apparently incoherently. I wanted to sit with him and listen to him. His words did not make sense, but I was sure that he was communicating something about his experience. I knew that what he expressed had meaning. As Garry Prouty says so simply– ‘there was someone in there’. I sensed his isolation and wanted to meet him, but of course this was considered very strange and naïve by the nurses. I did not last long in that hospital, nor in the one after that. I now realise that I did not communicate my different perspective well to the staff. I guess my interest and sensitivity did not go far enough: I got on fine with the

'crazy' people but understanding my hospital colleagues was a different story!

My **second reason** comes from my work as a therapist and from my experience as a supervisor and trainer of person-centred counsellors. For a long time I have been concerned about the limited development of theory and practice in relation to work with clients who experience complex psychological disturbance. In my opinion the lack of theory development in relation to mental health and psychopathology has had a detrimental effect on the standing of person-centred therapy as an approach that can make an important contribution in settings where traditional psychiatric and psychological treatments have been the norm. For many years, I used to teach on the topic of 'psychopathology' in person-centred counselling training programmes, but it was, and still is, difficult to find useful literature consistent with person-centred philosophy and practice. We need to continue to work on developing theory and practice to support and broaden person-centred therapy with people with whom it can be so difficult to make a relationship, who often crave relationship but also have a profound fear of relationship.

The **final** reason is related to the current pressure that we face in PCT in relation to the demands for evidence based treatments, for brief therapies that target specific symptoms. I am interested in the philosophical and political implications of how we meet these challenges in ways that are consistent with the philosophy of PCT, in how we engage with these political pressures without compromising the fundamental principles of PCT, and I have some concerns about the potential impact of these pressures on our work with clients.

slide 3

Here is my agenda for this presentation (read from slide)

### **Current philosophical and political challenges to Person-Centred therapy**

I think we are now in a very important phase in the development of PCT. Within the wider approach, what we refer to as the Person-

centered and Experiential therapies, there are many exciting developments. There is a fresh interest in theory, in dialogue and exchange of ideas, in communication between not only the different 'tribes' of the person-centred approach but also between different continents, cultural and language groups. In many ways the PCE is in good health.

#### slide 4

At the same time, we face considerable challenges. In the UK, as in other countries, there is pressure on counsellors and psychotherapists to meet the demands for evidence based practice, to prove that their way of doing therapy 'works' for specific client groups or client problems. Therapists are under pressure to select clients that are suitable for their approach, to develop problem specific approaches, to use treatments that will provide good outcomes in a short space of time. 'Symptom reduction' is becoming the focus of therapy, and only therapies that guarantee symptom reduction—quickly and cheaply—will be funded and supported by health insurance or healthcare providers or by the funders of educational and training programmes

Faced with such demands from governments and healthcare providers, and perhaps faced with a threat to our jobs, it is now more important than ever that PCT keeps in touch with its philosophical and ethical foundation. This was brought home to me recently when I read the new 'Handbook of Client-Centred Therapy', a joint Belgian-Dutch publication. In this excellent book the authors present their perspective on the state-of-the-art of the approach, giving an overview of the most current, up-to-date development of the theory and practice. The book is coherently constructed on what the authors identify as the the core principles, the fundamental principles of the (wider) PCE.

And here lies an enormous challenge, because who decides what is at the core of the approach? And what are the implications of the definition? Depending on what we see as core, as fundamental, we may have different views on the nature and purpose of therapy, we will have different understanding of the nature of disturbance, we will have different views on what constitutes effectiveness. Our philosophy

defines how we see our clients and how we see ourselves in our relationship with them.

Within what is often called ‘the family’ of the person-centred and experiential psychotherapies there is an ongoing debate on what constitute the fundamental principles of the approach.

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Germain Lietaer, one of the main authors of the Handbook mentioned before, makes a distinction between **first order** and **second order** aspects of the PCE. First order aspects are unique to the PCE and distinguish it from other therapeutic approaches. They represent the core values in therapeutic work with clients; they should be integral to training and supervision and are central in the evaluation of practice. **Second order** aspects are principles that are shared with other therapeutic approaches, in particular with the broad range of humanistic therapies. They represent universal values of psychotherapy but they are not unique, not distinctive of the PCE.

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Lietaer defines as first order (core) aspects

- Focus on the experiencing self
- Moment by moment empathy
- A high level of personal presence
- An egalitarian, dialogical stance
- A belief that the core conditions are crucial

As second order (general humanistic values) aspects he defines

- Wholistic person-centredness
- Emphasis on self- agency and the actualising process
- Self-determination and free choice as human possibilities
- Pro-social nature of the human being
- Autonomy and solidarity as existential tasks

Many of you here probably feel very comfortable with this succinct representation of principles; some of you may be delighted to see them spelled out so clearly and may be busy taking a note of them. So let me stir it up a bit.

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What if, as Peter Schmid argues, we change them around? These principles (on the left of the slide) now capture, in his view, the unique and radical philosophy of the PCE, with its respect for the absolutely unique nature of the person and for their capacity to shape and direct their own existence. The other principles are then about translating this fundamental philosophy in action, in the therapy relationship. This represents a different emphasis in the definition of the core of the approach– a definition in terms of the philosophical principles rather than in terms of therapist behaviour.

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So what about my perspective?

Fundamental for me is the respect for the client's self-determination and autonomy. That always comes first and is absolutely central in my relationship with my clients.

This is how I would describe the principles and challenges that underpin my therapeutic work and my relationship with clients. From this perspective, I am ready to fully engage with the client, be in a relationship where we can be both connected and free, where I have no wish and no responsibility to change anything in the other person. It represents freedom and responsibility; a relationship where we can be at the same time connected and autonomous, with an acceptance of the whole person as they are and with an appreciation of the unique way in which each person, each client, expresses themselves in our relationship. I want to acknowledge and accept the impact we have on each other and I want to meet the challenges that we both face as two human beings who are trying to be in relationship.

### slide 9

So– where are you?

Now I am not going to tell anyone what is the right position to take, or that you should adopt my perspective. But I do think that it is very important for person-centred therapists to explore what is fundamental to them, what motivates them in their work, what gives it

meaning, to articulate the philosophy that is at the core of what they do. Why? Because depending on what we see as fundamental, we not only will respond differently to the challenge and questions about the efficiency and the effectiveness of the approach, but we will also respond differently to the challenge in the relationship with our clients.

In my view, the biggest danger that faces PCT is not that it may disappear, but that it compromises its fundamentally radical and revolutionary philosophy and chooses a pragmatic adjustment to the demands of a culture that is based on a deficiency model and on the principle of social control– where those who do not fit in are punished, or are given treatment in order to make them adjust, or in order to silence them.

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The **deficiency model** of psychotherapy (which is closely related to the western medical model) may offer help and therapy, but the underlying aim is to cure or correct what is missing and, in some cases, to control deviant or challenging behaviour.

In contrast, PCT is fundamentally rooted in a **potentiality model** that respects and values the person and seeks to support them in the development of their potential, but that does not define for the client what that potential is or how it should be realised or expressed.

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**The two models do not mix.**

And we mix them when we focus on symptoms, when we devise protocols for the treatment of problematic behaviour or when we direct the client towards a healthier way of processing their experience. We mix them when we define the therapeutic relationship as an **instrument for changing something in the client**, when we focus on therapist behaviour, on technique.

**Can we avoid compromising that radical philosophy?**

#### Slide 12

First– let's have a look at history

The concept of psychopathology has for a long time been a controversial topic in PCT. Ever since Rogers addressed the '*problem of diagnosis*' (in *Client-Centered Therapy*, 1951) there have been uneasy debates about the understanding of mental health, about the development of psychological disturbance, about the value and meaning of diagnosis and about the nature and direction of therapeutic work with people who experience psychological disturbance or mental ill-health. Rogers did not exactly define 'mental health', but his concept of the 'fully functioning person' is often used as a model of a healthy person.

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In his famous 1959 chapter on '*The theory of therapy, personality and interpersonal relationships*' he describes '**psychological maladjustment**' as a state of vulnerability, caused by the development of **incongruence**: ...' *from the time of the first selective perception in terms of the conditions of worth, the states of incongruence between self and experience, of psychological maladjustment exist to some degree*'.

In the same paper he formulates a tentative hypothesis on the development of various specific forms of psychological disturbance. The concept of incongruence is central in this theory.

For Rogers, this definition of disturbance was descriptive; it was **never diagnostic**. He postulated that the six therapeutic conditions facilitate a movement towards greater congruence, but he never suggested that the goal of therapy should be '**the treatment of incongruence**' or that clients should be '**cured**' of their incongruence.

His focus of therapy remained firmly on the 'whole person', on the client's experience and on the relationship; the theoretical conceptualisation of the client's experience could only help the therapist to deepen their understanding of the client, not to guide the client's progress away from incongruence towards greater stability or congruence, or to a state defined as such by the therapist.

### Where are we now?

50 years after Rogers published his theory of personality, we have now an enormous, varied experience of working with people who experience all sorts of psychological distress. We have seen the

development of new ways of working– particularly through the influence of Gendlin, Elliott and Greenberg, Margaret Warner, but have we moved on much from Rogers early hypothetical formulation ? Fundamentally, we still see ‘psychological maladjustment’ as an internal state, located within the person, a personal problem; therapy is about creating an environment where the person can experience and explore that inner state– and perhaps where they can move towards a different inner state or be helped to change some of it or to change its effect on their behaviour.

Rogers was not interested in developing a comprehensive theory of psychopathology and psychological diagnosis. He distanced himself from a medical model in psychotherapy– the model of diagnosis, prognosis and treatment, where the therapist is a powerful expert. His statement that *‘therapy is diagnosis’* is for me as radical now as it must have been in 1951. He wrote this at a time when the medical model was dominant in psychotherapy. The therapist was the expert who diagnosed and prescribed treatment, who made judgments about health and disorder. This is in fact still the dominant model in psychiatry and psychology, and therefore what many clients expect from their therapist.

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Rogers’ statement was revolutionary. Not only did he suggest that the client ‘knows what hurts’, he also said that the client is the expert on understanding and making sense of their experience: *‘diagnosis is a process which goes on in the experience of the client rather than in the intellect of the clinician’*.

He then goes on to describe the therapeutic relationship as a place where client and therapist together are engaged in a constant process of discovering and exploring the meanings of the client’s experience. The relationship is the medium for this exploration– it is in the relationship that the client can experience herself more fully.

Nowhere in this formulation of the therapeutic relationship do we see a reference to pathology or disturbance. There is no need to develop a comprehensive theory of the origins of distress and no need for treatment protocols for specific difficulties. The therapist sees the

client as a person in process and the client's difficulties are understood as an expression of her experience or as an attempt to symbolise her experience.

However, the focus remains on internal world of the client.

In my experience as a therapist, this conceptualisation fits well with some clients, because this is close to how they experience their difficulties. They seek to understand themselves and they experience their difficulties as located within themselves. They experience conflict or incongruence in some way and this is what brings them to therapy. Rogers' personality theory and theory of therapy fits well for the clients that he described in the Wisconsin project as 'Chicago neurotics', but as that study showed, when working with clients who expressed their experience differently (who were diagnosed as schizophrenic or seriously mentally ill) some of the therapists who took part in the project struggled.

Why? I think it was because they found it difficult to meet the different **relational challenge** in the work with the hospitalised clients.

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I suggest that we need to develop our conceptualisation of disturbance and distress and move away from an understanding of it as an experience or process located **within** the client to an understanding that is based on **relationship**. These are the questions we may ask ourselves:

- Is disturbance an internal state or is it relational
- Can I meet the client in their *fear* of relationship?
- Can I be open to what happens to *me* in our relationship?

In this final part of my presentation I want to invite you to consider with me how we can integrate a relational perspective in our work with clients who are 'difficult' because of the way they struggle in their relationship with themselves and with others. These are the people with whom it can be terribly difficult to make a relationship, because of their **fear** of being known, of being met. These are often the clients who are most disempowered, who are not considered suitable for therapy but are given medication instead. Sometimes they are offered cognitive therapy because it is assumed that they are too vulnerable and cannot deal with emotion and with relationship. The paradox

seems to be that the more the person shows their desperate need for relationship, the less likely it is that they will get it.

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These are my propositions:

- *There is always a relational dimension in the experience of disturbance*
- *Disturbance is a symptom and a symbol; it represents the person's effort to survive challenging (relational) circumstances and it is an expression of their experience.*
- *I accept and respect disturbance as a part of the whole person, as an expression of their self experience, but I do not see the person as defined by it*
- *I accept the challenge that the client's self-experience and relational experience may bring to our relationship and I hope to be able to meet them fully in that challenge*

Psychological disturbance is not only about the client's inner experience. It is experienced and manifested in relationship with others, including in the relationship with the therapist. The client's way of experiencing themselves and their relationships becomes visible in the therapy relationship. I experience with the client her world, not only through what she tells me about her history or through her exploration of important relationships in her past or current life. I experience it directly- through what she tells me about her experience of me, in what she tells me about what she hears me say, in her response to me. I become aware of her sense of herself not only through her story and her reflection on her experience, but also through my direct experience of her.

To be able to meet the person fully requires of me the willingness and capacity to meet her exactly as she is in relationship with me. It is in our relationship that I can feel her fear, her need for closeness, her distrust, the ways she protects herself. I can experience her new found confidence and her anger with me when I don't understand her.

Through meeting the challenges in our encounter, as PF would say, I can get a real taste of **what it is like to be her.**

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As Dave Mearns says in his keynote lecture at the 2003 PCE conference in Holland: *Client processes are both barriers and gateways to engagement at relational depth. The mark of a 'good' person-centred therapist is that she is willing to offer a relationship to clients who are ambivalently resistant to relationship.*

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My client also challenges me to be open to all of myself in the relationship; being real and present with the other person requires an openness not only to all parts and dimensions of the client, but also to all aspects of my self in the relationship with her. This is the real meaning of congruent relating.

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This is what a relational formulation of the therapeutic relationship might look like:

- In the therapy relationship we experience the dynamic processes within the client, within the therapist and in our relationship
- It is the responsibility of the therapist to seek to understand and meet the client's unique way of being in the relationship
- Such depth of relating makes it possible for the client to experience themselves more fully

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- The therapist is also aware of the cultural and social experiences that are part of the client and that are therefore present in the therapy relationship.
- The therapeutic relationship is unique and created by both people. It is not problem specific and not designed to cure the client's symptoms.

Let me show you what this might mean in practice, with a client.

*What follows now is a brief casestudy. For reasons of confidentiality I have of course disguised actual details and I have drawn on my*

*experience with many clients to illustrate the challenge and impact of the relationship.*

Ameena is a woman in her late twenties, with beautiful long black hair and a striking appearance. She is a successful creative artist, respected for her innovative arts work in poor parts of our city.

She has come to see me because she feels she is in a mess after the break-up of a stormy relationship. She has been feeling depressed, has had some panic attacks and cannot concentrate on her work. She drinks a lot, smokes dope and has started to take 'speed' (amfetamines) to keep herself going during the day. She feels exhausted. A friend has pushed her to seek help and has more or less brought her in for the first session.

Our relationship in fact started before we met; she phoned me to enquire about what I could offer and practically interviewed me over the phone. I seemed to have 'passed the test' but then when we got to the point of making an appointment, she almost aggressively told me that she could not possibly travel that far to see me. I felt a bit rejected and angry. Then a week later, she called again; she had discovered that she could make it to my office. We made an appointment but to be honest, I had some reservations about seeing her- I felt she had messed me around and wondered what more I could expect.

In our first meeting Ameena talks almost non-stop; she looks tense, almost scared. She laughs nervously and tells me in a dramatic way about her last partner and the break-up- as though she is telling me about a play or a film. I feel like I am an audience; I don't like her very much; then I realize I don't feel comfortable with her- I am a bit scared of her and I am keeping my distance. But I remind myself that I am there as a therapist and that I need to make an effort to respond to her and make a connection with her, to let her know that I have heard her. So I respond- but I know I am not congruent. We make another appointment and I wonder if she will come back- I don't feel good about the session. I talk about it in supervision and realize how distant and defensive I have been. I feel I have let her down. When we meet again- yes, she did come again- I say:

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E. Ameena, I would like to talk with you about our last session I was not happy with how I was with you– I am sorry about that. Can we talk about it?

A. *Smiles.* ‘ I know’

E. (*feeling nervous*). OK– you knew?

A. yes, I am really good at reading people’s minds. I could see you were trying to be helpful, but I knew you were uncomfortable. I am used to that. I always seem to make people uncomfortable– especially women of your age.

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Must be my mother complex

(*Laughs*). Or maybe they are just jealous. But I will give you another chance.

E. Ok– thank you (*I smile and I decide to leave what I thought I needed to say. We seem to have started. This going to be a challenge, I think*)  
OK– shall we start again then?

*Had I been focused on her ‘problem’ I might have chosen to pick up what she said about her mother complex. Or I could have picked up on any of the things she said there– eg her smile, her sarcasm. I might have wondered about conditions of worth when she says ‘I always make people uncomfortable’. Instead, I am just glad to get another chance and I can live with not knowing what she is talking about here. This really feels like **relationship** is our challenge.*

In our next twenty sessions I often find it difficult to respond to her. It is hard to get a sense of what she is experiencing. She may seem overwhelmed by feelings, but when I try to reflect my understanding of what she is saying, she backs off. At other times she is vague, almost bored. I feel I am on tightrope: if I don’t get it right I lose contact with her, at other times she acts as if I am too close.

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A. (*Looks very sad*) I guess I had hoped that this time it would be different, that perhaps I could be with someone for the rest of

my life, that someone could put up with me and does not want me for my looks or my body

E. You are really sad and disappointed– you wonder if you will ever find someone who loves you for who you are.....

A. *(looks annoyed and speaks sharply)* Here we go again– is this what you call ‘advanced empathy?’ Just leave me alone– I don’t need your clever insights!

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E. *(I am a bit shocked. I ask myself– was I being clever? I don’t know what to say now. I felt sad when she was talking and now I feel shut up– I feel a bit hurt)*

*I say with some sadness:* I know, you just want be left alone...

A. Well, yes and no– I don’t know what to do when you say these things, it makes me feel weak....because it is kind of true

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E. yes, I can see that. It is hard for both of us. I really do want to understand what is going on for you and sometimes I really feel it, I feel moved when I listen to you– but it is not always ok for you to hear me say that. *We sit in silence for the rest of the session.*

*I want to let her know that I understand some of what she is telling me, but I am also careful not to focus it all on her, to make it her problem. WE have a problem.*

That night I read some of Margaret Warner’s writing on fragile process. It does help me – it gives me another perspective and helps me to keep my focus on Ameena, to be ‘personal’ with her but not to take what she says personally. I need all the help I can get to stay open to her; thinking about fragile process broadens my imagination about what may be going on for her. I feel I am still fighting for the relationship.

The therapy is at times extremely challenging. Her mood can change very quickly between being suicidal and feeling full of confidence. She shows me the cuts on her arms and tells me with a little smile that she has more, in other places.

She gets furious when I go on holiday. For a while we see each other twice a week because she is so frightened of what is going on in her. She tells me I am the best therapist she has ever had and she dreams

about me, talks to me in her head. Sometimes she does not turn up. Sometimes she only stays for half the session.

*Had I taken a more problem or symptom focused approach, I might by now have diagnosed Ameena as having a borderline personality disorder. I might wonder about whether she can benefit from person-centred therapy. I might have focused on her style of communicating- perhaps we would have done some CBT exploration about why she gets so angry so quickly. We could have looked at her self-harming behaviour and explored more healthy ways of managing her feelings. We might have explored her unrealistic expectations of relationships. Perhaps I would have worked with the fearful part of her that feels she is not worthy of love- or I could have encouraged her to be more positive and hopeful. Sometimes I wonder if I am doing enough.....*

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session 36:

*Ameena starts the session, a bit aggressively.*

- A. See when you said that time that you were not happy with how you had been in our first session. What was that about? What did you mean? You never explained it; you just told me and I have been thinking about it ever since. It made me feel really unsafe- I nearly cancelled today.

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- E. I know, we did not really talk about it that time and I am sorry that it made you feel unsafe. I can see how that could happen, how that would have affected you. I am glad you did not cancel and I would like to tell you more- are you ok with that? *(I want to make sure that she really wants to talk about this- and I feel a bit nervous..)*

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- A. That is why I brought it up!
- E. Well, I realized that I was bit wary of you because of what happened in that first phone call, when you suddenly said you could not travel here, and then you changed your mind. I was not sure what was going on for you then . I was wondering if you would do the same when we met, that you would leave after one session. But then I realized after that first session that I had

been distant and defensive. I did not think I had done a very good job.

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- A. OK– I can see that. I know I can have that effect on people. I confuse them. *(Smiles)* I don't suppose I can get my money back for that session?)
- E. *(I smile too. We look at each other)*

I feel really moved, and also excited. Ameena takes a big risk here. She tells me that she is frightened– she nearly did not come. I believe her and I want to honour her request that I am honest with her– and that is risky for both of us. That is why I ask her 'are you ok with that'–to be honest, I guess I am asking myself there too. She is asking a real question and I need to give a real answer. I know we are ok when she makes the joke about the money. She knows it too.

*In a more problem focused approach I could have focused on her fragile process and I might have explored her fears of abandonment, perhaps her early experience of insecure attachment with her mother. Perhaps I would have reassured her and helped her to see that her fear was based on fearful thinking that comes from a particular condition of worth. I might have used focusing to help her get in touch with what is **really** going on underneath that fear. I might have avoided being vulnerable myself.*

There continued to be many challenging moments in the relationship and I felt that Ameena really asked of me to be present with her, to take risks and show myself. I did not make a diagnosis. We never **worked, focused** on her problems with partners, her relationships, her fear of failure, the fact that as a Muslim woman she could not be open about her sexual orientation (she was gay). We talked about all these things, and she sometimes came up with interesting solutions or strategies. Sometimes we both did. She also said she did not really like a quiet life– she would miss the drama.

I think that more than anything she sought a real relationship where she could be herself, where she could feel accepted as she was, where both her need and her fear of relationship was met. The whole therapy

was about our relationship, about trust. We stopped the therapy , after 55 sessions, when she said that it was time to stop

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A. I know I will be ok on my own now

Working with the relationship is not easy. If I really open myself up to the other person, I may feel uneasy, fearful, threatened, attracted, angry– all sorts of experiences will happen in me when I am touched by the other person. It can be very challenging to stay in the relationship, to stay open to the client's experience and not seek the comfort of the role of the expert or hide behind an interpretation of transference and counter transference, not guide the client to what I believe would be integration of experience or movement towards congruence. Therapy is not about giving a specific response for a specific problem; it is about responding uniquely to each unique person and about staying open to the challenge that we create together. It is hard work.

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In this time of challenge to PCT it is more important than ever to keep firm to the radical and revolutionary philosophy that puts *relationship* at the heart of the therapeutic encounter.

The experience of relationship has the potential to put us in touch with our own humanity and opens up new dimensions of ourselves. In such a relationship, the client's disturbance is accepted as an expression of their unique way of being, and the challenge that this creates in the relationship is fully acknowledged.

Such experience of relationship gives the person a new experience of themselves. It helps restore hope and trust in their capacity to live their life in whatever way is best for them.

That is what my clients tell me, and I believe them.