ONE Person-Centred and Experiential Psychotherapies in the 21st Century

Paul Wilkins

Introduction

The purpose of this book is to exemplify contemporary trends in person-centred and experiential therapy and, specifically, to illustrate how they are actually practised. It is not (primarily) a book about the theoretical bases for the different tribes of the person-centred nation and theories underpinning work in specific settings. Explaining this has been well done in other works (for example, Sanders, 2012; Cooper et al., 2013). The emphasis on practice is what gives the book its unique flavour and which makes it particularly useful to students and practitioners of counselling and psychotherapy.

As indicated above, this book follows on from a variety of descriptions and categorisations as to what constitutes the ‘tribes of the person-centred nation’, and the theory supporting these different approaches (see Sanders, 2012), and picks up where Tolan and Wilkins (2012), which addresses how a range of ‘client issues’ may be worked with in a person-centred way, leaves off. To be more explicit and more personal, when reading the chapters in Sanders (2012), I found myself thinking, yes, I understand the ideas behind your practice but what do you actually DO? How do you implement what you have taken from the classical client-centred therapy roots from which your approach
springs and how do you do things differently? I assume that this is a question posed by others, or at least that others would be interested in the answers. This led to Part One of this book, which addresses some of the approaches to therapy that have developed from classical client-centred therapy as it was set forth in the 1940s and 1950s. These are:

- Classical Client-Centred Therapy
- Dialogical and Relational Aspects of Person-Centred Therapeutic Practice
- Focusing-Oriented Therapy
- Experiential Therapy
- Emotion-Focused Therapy (EFT)
- Person-Centred Expressive Arts Therapy

This section also includes Tracey Walshaw’s chapter ‘Creativity in Private Practice’. This is because, although she points out that she doesn’t belong in any particular tribe, indeed because she doesn’t, her way of working epitomises the freedom the person-centred approach offers for practitioners to develop their own way of offering the therapist-provided conditions and adhering to Sanders’ principles of person-centred therapy (see below).

I am aware that while the book I edited with Janet Tolan (Tolan and Wilkins, 2012) does a good job of presenting how person-centred practitioners work with a range of issues with which they may be presented and which are of great importance (for example, bereavement, sexual abuse, drugs and alcohol issues, and experiencing ‘reality’ in different and sometimes disturbing ways), there was so much we were unable to include but about which person-centred practitioners have much to offer and to say. Part Two of this book picks up on some of the contemporary person-centred practice which contributes to theory and advances and broadens the approach as a whole. The chapters are:

- Client-Centred Therapy and Post-Traumatic Growth
- Person-Centred Work with People Experiencing Disability
- The Person-Centred Approach to Transcultural Issues in Therapy.

Regardless of its place in the person-centred nation, the core of each chapter is a number of vignettes illustrating practice. However, in no case can these vignettes be taken to represent the ‘right’ or only way to practise the particular approach. Each practitioner contributing to this book has their own way of being in the world which they bring to their practice – sometimes in an idiosyncratic fashion. In her chapter, Tracey Walshow owns this idiosyncrasy and claims it as a strength. She argues that just as no person-centred practitioner would seek to confine and
restrict the way of being of her clients, it is nonsense that they should force themselves into some predetermined and prescriptive way of practising. While stressing the importance of having a good understanding of person-centred theory and holding to person-centred principles, she says ‘there is strength in each counsellor’s authentic, individual and creative interpretation of Rogers’ theories’. In different ways, this applies to each contributor and can be seen, from the development of Gendlin’s focusing onwards, as one of the forces driving the development of new branches of the person-centred nation and new ways of implementing person-centred practice in new areas, with particular client groups and particular client issues. In his ‘posthumous conversation with Carl Rogers’, Kirschenbaum (2012: 21–24), who is Rogers’ biographer, draws on his extensive knowledge of Rogers and his writing to affirm that Rogers was more interested in practitioners and theorists developing their own ways of being person-centred than blindly following a way with which he was comfortable for himself. Warner (2000: 30) also refers to Rogers’ commitment to the self-direction of all people – therapists as well as clients. In a way, this sanctions not only the development of person-centred therapy’s tribes but also the individuality and idiosyncrasy of person-centred practitioners. We are charged with being the best person-centred practitioner we can be. That affects how we choose our tribe, our speciality (or generality) and how we conduct ourselves with our clients.

The root of the person-centred family tree

In order to understand something of the branches of the person-centred family tree (the tribes of the nation), it is probably helpful to explain and contextualise the root from which it springs. Person-centred practice, however it is now carried out, is founded on theory based on empirical observation and research. What this theory is and the work from which it arose was described by Rogers and his colleagues in the 1940s and 1950s. The aim of Rogers and his students was to understand the process of therapy and what led to constructive change. Rogers (1967: 244) framed the theory of client-centred therapy ‘not as dogma or as truth but as a statement of hypotheses, as a tool for advancing our knowledge’. The concepts underpinning person-centred therapy were and are being constantly reappraised and revised in the light of clinical experience and research. There is not, nor was there ever intended to be, some ideal, ‘pure’, never changing way of doing person-centred therapy. However, there are core values and principles underpinning person-centred practice (see below). While there is some discussion and negotiation to be
had with respect to these (for example, it can be agreed that it is impor-
tant that clients are not directed but argue as to what constitutes a non-directive way of practice), to be person-centred an approach to therapy must draw substantially on the ideas set forth in Rogers 1951, 1957 and 1959. It is in these works that Rogers sets forth ideas about the nature of the person (for example, as ‘nineteen propositions’; Rogers, 1951: 483–522), the process of change, the roots of mental and emotional distress and his famous hypothesis of the necessary and sufficient conditions (1957: 95–103, 1959: 213). He also defines the actualising tendency (1951: 487, 1959: 196–197). Also of importance are the seven stages of process as a model for therapeutic change (see Rogers, 1967: 132–155).

These statements of theory are not explored here or elsewhere in this book and are only referred to briefly, if at all. However, there is an assumption that readers will have at least some grasp of basic person-centred theory. If you need a refresher, try Sanders (2006, 2013a) or Wilkins (2010/2015).

The person-centred nation and its tribes

It was Warner (2000: 28–39) who first described person-centred psychotherapy being one nation of which there were many tribes. She describes five ‘levels of interventiveness’ (pp. 31–33). Briefly, these are:

1. The therapist is in contact with the client without bringing anything from outside the client’s frame of reference.
2. The therapist uses personal experiences and theories as a way to more fully understand the client’s frame of reference, without trying to influence or alter the client’s experience.
3. The therapist brings material into the therapeutic relationship, doing so in ways that foster the client’s choice as to whether and how to use such material.
4. The therapist brings material to the therapy relationship from his or her frame of reference from a position of authority.
5. The therapist brings material that is outside the client’s frame of reference in such a way the client is unaware of interventions and/or the therapist’s actual purposes in introducing the interventions.

Warner (2000: 33) believes ‘that [a] fundamental dividing line occurs between the more client-directed therapies grounded in Levels 1–3 interventiveness and the more authoritative therapies grounded in Levels 4–5’. That is to say that all person-centred therapies operate on
levels 1–3 – but this doesn’t mean that all level 1–3 therapies or therapists are necessarily person-centred. Practitioners of person-centred therapies share a set of core beliefs drawn from client-centred therapy (p. 35). Sanders (2012: 238–239) stated the necessary theory underpinning person-centred practice and listed them as primary and secondary principles. The former are ‘required’ and define the broad family, the person-centred nation; the latter are permitted in the sense that they bring practice closer to the classical client-centred approach as defined in the 1940s and 1950s. Adapted as characteristics of person-centred therapy, these are:

Primary principles

- The actualising tendency has primacy. It is required to believe that the process of change and growth is motivated by the actualising tendency and it is an error to act otherwise.
- Constructive, growthful relationships are underpinned by the active, attentive inclusion of the ‘necessary and sufficient’ conditions described by Rogers (1957).

Secondary principles

- There is a right to autonomy and self-determination. It is a mistake to violate the internal locus of control of another/others.
- A ‘non-expert’ attitude underpins relationships with others. It is a mistake to imply expertise in the direction of content and substance of the life of another. In this sense at least ‘equality’ is fundamental.
- The non-directive attitude and intention have primacy in that it is a mistake to wrest control of the change process from the actualising tendency in any way whatsoever.
- The therapeutic conditions of Rogers (1957) are sufficient to enable encounter. It is a mistake to include other conditions, methods or techniques.
- Holism – it is a mistake to respond to only part of the organism.

Sanders (2013b: 46–65) revisits the ‘family’ of person-centred and experiential therapies explaining how core values are seen by different authors (pp. 47–50) and characterising classical non-directive client-centred therapy: ‘the pure form’ (pp. 50–52) and ‘developments from the “pure form”’ (pp. 54–59). The developments Sanders considers are:
Focusing-oriented psychotherapy (pp. 54–55)
Process-experiential psychotherapy/emotion focus therapy (pp. 55–57)
Encounter-oriented (dialogical) approaches (pp. 57–58)
Pre-therapy (pp. 58–59)

In each case he gives the history and theory of the approach, briefly describes its practice and explains how it fits in to the person-centred family.

In a previous work, Sanders [2012] presents ‘an introduction to the schools of therapy related to the person-centred approach’. Herein are chapters by exponents of a variety of tribes of the person-centred nation which give the history of their modality, explain something of its theory and workings, give an account of relevant research and list relevant resources. Core chapters are:

Classical client-centred therapy (Merry, pp. 21–46)
Focusing oriented therapy (Purton, pp. 47–70)
Experiential person-centred therapy (Baker, pp. 71–102)
Emotion-focused therapy (Elliott, pp. 103–130)
Existentially informed person-centred therapy (Cooper, pp. 131–160)

There is also a chapter on ‘new developments’, including brief accounts of ways of doing person-centred therapy, which Sanders does not consider to have reached full ‘tribe’ status. These are:

Person-centred expressive arts therapies (Brown, pp. 187–200)
Pre-therapy and contact work (Sanders, pp. 201–210)
Relational depth in person-centred therapy (Knox, pp. 211–222)
Counselling for depression (Hill, pp. 223–230)

It is to this book that readers could usefully first look to find out more about the history and theories of the approaches to practising person-centred therapy described in this book.

Broadly speaking, there are five major approaches within the person-centred nation. These are classical client-centred therapy (classical in the sense that it represents a well-known ‘traditional’ pattern) and four major branches arising from the client-centred therapy trunk. One way in which these approaches differ is in the level of interventiveness at which they operate. This is indicated in each brief description. However, levels of interventiveness are subjective and also depend on how the individual practitioner works with the individual client. This may vary as the relationship matures, between therapists and between clients. Others may take a different view from the one expressed here. These approaches are concerned with:
• **Empathic understanding, unconditional positive regard, therapist congruence and the other three necessary and sufficient conditions and only these. The client’s actualising tendency is the engine driving change.** This is classical client-centred therapy as first developed by Rogers and his colleagues and students. In its modern-day form, it is characterised by a belief that being non-directive is of primary importance. Indeed, for some of its practitioners, this is an ethical issue. Many of the major principles of this approach were stated in the major works of the 1950s [including Rogers, 1951, 1957, 1959]. This approach is represented in this book by the chapter ‘Classical Client-Centred Therapy’. In Warner’s terms, classical client-centred therapy [at least ideally] operates on level 1 interventiveness.

• **‘Experiencing’ and processing**, of which Gendlin [see Gendlin, 1962] and Rice [see Rice, 1974: 289–312] are progenitors. This branch of the family is represented in this book by focusing therapy [Glenn Fleisch], experiential therapy [Graham Westwell] and emotion-focused therapy [Rhonda Goldman and Jeanne Watson]. These approaches may be considered to operate on level 3 interventiveness.

• **Encounter, the relationship and dialogue**, the basic idea being that it is in the co-created, intersubjective relationship between client and therapist is where change happens. If you like, it is the space between [the overlapping bit of a Venn diagram] where a real meeting of persons occurs and such meeting facilitates change. The emphasis is thus on the encounter [which is somewhat different from ‘relationship’] and shared experience as much [or more] than on the client. Barrett-Lennard [2004] and Mearns [see Mearns, 1996, and Mearns and Cooper, 2005] have contributed much to the development of this approach to person-centred therapy, but perhaps it is from the work of Schmid [for example, 1998, 2002, 2006] that it has gained prominence. This approach is represented in this book by the chapter ‘Relational and Dialogical Aspects of Person-Centred Therapeutic Practice’ [Steve Cox]. This approach primarily operates on level 2 interventiveness.

• **Contact**, that is to say working towards meeting the first of Rogers’ necessary and sufficient conditions, the requirement for [psychological] contact, with people who through illness or injury [physical or psychological] are ‘contact-impaired’. Contact work is best known through the work of Prouty [see Prouty, 1994, Prouty et al., 2002], who developed ‘Pre-Therapy’. While it represents a major off-shoot of the client-centred trunk, pre-therapy and contact work are not represented in this book. This is because there are many excellent accounts of its practice [see, for example, Sanders, 2007; Van Werde and Prouty, 2013]. As its practitioners explain it, because contact work is about responding to the client’s way of being in the world and only that, it operates on level 1 interventiveness.
The use of creative arts. While the notion that incorporating painting, dancing, creative writing and/or drama into person-centred therapy would seem to be about introducing ‘techniques’ and therefore anathema (to at least some), there is now a long tradition of therapists who are rooted in person-centred attitudes and values incorporating expression through art-based media into their work, so much so that I think they constitute a tribe of their own. What therapists who work in this way are very clear about is that they offer their clients opportunities to engage with art materials, found objects, music, etc. They do not ‘direct’; rather they follow and facilitate. There are many routes to incorporating creative and expressive arts into person-centred therapy – for example, as art therapy (see Silverstone, 1996) and psychodrama (see Wilkins, 1994), but a major contributor has been (and is) Natalie Rogers, who developed Person-Centered Expressive Arts Therapy (see N. Rogers, 1993, 2013). Creative approaches to person-centred therapy are represented in this book by the chapter ‘Person-Centred Expressive Arts Therapy: An Experiential Psychology of Self-Realisation’ (Terri Goslin-Jones and Sue Ann Heron) and Tracey Walshaw’s chapter, ‘Creativity in Private Practice’, in which she shows how she brings her experience with a variety of expressive forms to the core of her practice. The level of interventiveness at the heart of person-centred therapies having creative and/or expressive arts at their core varies with the practitioner and setting. It is normally either level 2 or 3 and perhaps can move smoothly between these.

While the practitioners of any of these approaches may have and exhibit a strong preference for their own particular tribe, nothing as to the relative merits of any one tribe with respect to the others is necessarily implied in this book or in the various national and international forums in which person-centred therapists meet. The ‘classical’ approach is only classical in the sense that it came first and the theory and practice underpinning it are the bedrock on which practitioners and theorists of other tribes built. Similarly, while each of the other tribes constitute developments, these are not necessarily ‘improvements’ – at least not in a global sense. Rather than considering the different tribes to be in some sense rivals, it is better to think of each offering something different to both practitioners and clients. Both have the chance to choose something appropriate to the needs and ways of being in the world.

As person-centred practitioners, we are each charged with being the best therapist we can be. How we choose to operate depends on our personal philosophy and experience. For some, this may lead in the direction
of emphasising the non-directive attitude and the therapist-provided conditions, others may be persuaded by an emphasis on guiding a client’s micro-processing, yet others may find introducing creativity into their work enables them to optimise their therapeutic skills while some (without losing sight of a solid grounding in person-centred theory) may blend approaches to suit themselves and their clients. None of these approaches is ‘better’ than the others, nor is it necessarily more effective. What matters most is that each of us finds what way of practising person-centred therapy works best for us and our clients.

Person-centred practice, life events and life circumstances

Historically, there has been some resistance to exploring how person-centred therapy might be at its most effective with different client presenting issues. This is because the six necessary and sufficient conditions can be seen as all that is required to ensure constructive personality change regardless of what the client thinks or feels the ‘problem’ to be. That is to say, to pay primary attention to the presenting issue turns a person-centred approach into a problem-centred approach. The focus is no longer upon the client and the relationship but on whatever the client indicates (or, worse, what the therapist thinks) has brought them to therapy. However, making strong links to person-centred theory, Wilkins and Tolan (2012: 163), while stating categorically that ‘regardless of the presenting issue the client brings, the right and proper way to be in response to them is to offer the therapist-provided conditions’, argue that there is benefit in therapists having ‘specialist knowledge’ of specific life events (for example, bereavement, depression, eating problems) and particular client backgrounds. This is because it can (and usually does) facilitate the congruence, empathic understanding and unconditional positive regard of the therapist. They say:

It is only when we understand something of how the client might feel (or not feel) in response to what they have experienced, and are able to accept that what on the face of it looks like damaging or even deplorable behaviour – is, in some way (however distorted) – constructive or protective, that we can fully empathise and accept the other. It is only when we can see the person beyond their manifest incongruence arising from distortion, denial, an external locus of evaluation and their conditions of worth, that we can be a companion on their sometimes painful journey towards growth. It is knowledge of the what, why and wherefore of things that can help us do this.
So, knowledge of the sorts of things people may experience and how they may react to those experiences can be helpful—but only as long as it doesn’t result in a simplistic, unipolar, problem-centred attitude to clients. It is rare that a person presenting for therapy [or anyone for that matter] has just one issue which can be treated in an almost formulaic way. The circumstances leading to the same or similar issue are likely to be different for different clients (for example, Douglas (2012: 131) is clear that eating difficulties can arise from a variety of life experiences) and the same initiating event (for example, bereavement) may lead to entirely different client reactions. Also, reactions to any life event and/or personal circumstance are likely to be complex and various. For example, someone who has been bereaved may also be depressed, may have problems with food, could self-injure or experience any of these (and more) in combination. So, to focus on a client presenting issue such as bereavement to the exclusion of all other things would be a mistake. At the same time, being aware of a person-centred understanding of loss and bereavement (see Haugh, 2012: 19–23) and, while having some grasp of them, not becoming too focused on the stage or process theories of grieving (see Haugh, 2012: 17–18), may be helpful when working with a grieving client. It is on the assumption that knowledge of this kind is likely to be helpful to person-centred practitioners that the second section of this book is predicated. Also, there is a point to be made about the person-centred therapies and their applicability. Person-centred practitioners have been working with clients of many kinds and have developed theory and codified practice. This has included:

1. People experiencing severe and enduring distress, including the area of psychopathology (see Joseph and Worsley, 2005; Worsley and Joseph, 2007) and ‘the difficult edge’ (see Pearce and Sommerbeck, 2014), and ‘difficult process’ (see Warner, 2013).
2. Life events and reactions to life events, such as childhood sexual abuse, anxiety and panic, drug and alcohol issues (see, for example, Tolan and Wilkins, 2012).
3. Life stages, including childhood and adolescence (see, for example, Behr et al., 2013), being older (see, for example, Pörtner, 2008) and couples and families (see, for example, O’Leary and Johns, 2013).
4. Life circumstances – that is to say things pertaining to the cultural milieu from which we spring [for example, class, ethnicity, culture and gender], ‘difference’ from [before] birth [for example, autism, sexual orientation, some physical or mental disabilities] or because of life-changing events (such as accident, trauma or disease leading to changes in physical or mental abilities).
Again, it would be a mistake to simply categorise people and to proceed as if the box into which they seem to ‘fit’ is sufficient to provide answers to their therapeutic needs. Mostly, although it may be a contributory factor, it isn’t ‘being different’ alone which brings a client to therapy, although it may frame the client’s experience, thoughts and feelings. For example, in her chapter, Connie Johnson notes that it is important to recognise that being disabled involves living with particular stresses and strains and that many disabled people say that they would like their counsellors to know about this aspect of their experience. The nature of a client’s difference may very well add a layer of complexity to their way of being in the world. That the therapist understands this is likely to be helpful. So, to stick with the example, Johnson says that although most disabled people come to counselling for the same reasons as others, disability is very much a part of their lives and affects them emotionally and in relationships in ways that are not always apparent, even to themselves. This can be difficult to talk about and may create awkwardness or a lack of authenticity in the therapeutic relationship. It is not always easy to find appropriate language to talk about disability or anything else that contributes to a client’s sense of being and/or feeling different.

In his chapter on transcultural counselling, Colin Lago writes of the need to understand the oppressive and discriminatory behaviours to which clients are likely to be exposed. He says that not to understand these limits empathy and unconditional positive regard and therefore the effectiveness of therapy. He goes on to say that it is important to understand the ‘problem’ in its cultural context and to appreciate the impact of the client’s cultural experience. While Lago is writing specifically about issues of ethnicity, race and culture, what he says applies more broadly to the experience of being ‘different’ as a whole. It is therefore helpful to effective person-centred practice for the therapist to continually address and advance their understanding of difference in all its multifariousness. The chapters in the second section of this book are aimed at helping person-centred therapist to do this by addressing some recent advances in theory, practice and understanding of others. Thus, Murphy and Joseph’s chapter on post-traumatic growth pertains to the first and second of the above categories, while Lago’s chapter on transcultural counselling and Johnson’s on working with people who are physically disabled are to do with the fourth.

The structure of the chapters

Because the emphasis of this book is on the manner of practice, theory is addressed but briefly. However, the authors indicate where readers
can find out more about their particular approach, both by in-text references and in the form of a guide to further reading. Nevertheless, in their own ways and to varying extents, the chapter writers introduce the history, context and theory of their approach or way of working. The core of each chapter is a number of case vignettes indicating aspects of practice which the writers think to be of particular note or helpfulness in understanding what they do. Depending on their nature, the chapters also include a degree of evaluation, and some reference to research.

References


