Understanding the Person-Centered Approach to Therapy: A Reply to Questions and Misconceptions[1]

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As a first step in introducing the approach that has been uppermost in my own professional life, I would like to briefly introduce myself: my attitudes, interests and bent:

1. I see myself as pretty resistant to orthodoxy--to a standardized or fixed way of thinking and practice. I also get tired of simply repeating myself: hence, for example, this fresh statement. My excitement comes more from pushing out boundaries, breaking new ground, extending or building onto the views or understanding I have already, than from preserving ideas intact. This side of me was reflected in the step of leaving Perth and the local psychology scene, as of the early 1950s, and sailing to distant Chicago to take part in the wave-front of new thinking around Carl Rogers' work. It also meant involvement with other seekers in a rare and special educational-academic environment, the University of Chicago. The same tendencies influenced what I felt my way into on returning to Australia.

   The job I came back to was at the University of New England, then small and isolated. The rather restricted and set activity of lecturing undergraduates, more or less in accord with a prescribed syllabus, wasn't really my cup of tea, especially by itself. After a bit of casting around I took the plunge of pioneering small group learning and development workshops for people in the mental health field, workshops which brought colleagues in several disciplines and from across Australia, into residence together to take part in intensive training/learning and personal development groups. A few years later, I returned to North America and then wound up going to one of the newer universities in Canada to start and develop a graduate programme in the counselling and human relations sphere. My last major transition entailed leaving institutional academia, except for nominal affiliations, and launching out on an independent path. The things I most valued in university settings are still features of my work, with some important changes in emphasis and added dimensions.

2. The second aspect of myself is already implied. I am not a *typical* practitioner, if indeed there are any such. I spend more time thinking about and searching into what I do, than in the practice itself. Overall, I have pursued research in several of my main areas of interest, have learned a great deal through my teaching and supervision, and feel much enriched by my pathway of practice experience; each of these levels also sparking new things on the others.
3. My interests have moved over time from an originally fairly exclusive focus on individual psychology and one-to-one therapy to include gradually widening interpersonal and social dimensions. The first expression of this was a strong and continuing research interest in two-person life relationships. Then came the focus already implied, in small group processes and relations (especially, experiential learning groups) and later, a careful interest in family relations and systems, and in organisational processes and the nature and working of community.
4. In recent years I have, nevertheless, been more engaged in therapy than during my full-time academic career. This concentration of experience has been very satisfying; and I feel it has deepened my thinking and awareness in important ways. The interested attunement I now have to small and larger systems feeds into my work and thinking as a therapist and this work in turn helps to inform my ideas and concerns regarding family relations and the working of larger systems.

So much for a few personal/professional self-observations, a self which my pathway reflects and also contributes to. What I can share in a short space about a system of thought and practice developing for half a century, and absorbing to me throughout my career, can only be a preview. The way I have chosen to do this is to frame and then 'reply' to several questions and misconceptions regarding the approach. I will start with a question:

Could a person who is substantially influenced by another orientation or system of thought also engage fruitfully with ideas and practice linked to the person-centered approach?

In reply, I will reflect first on my own experience:

I have been influenced by other perspectives; psychodynamic, humanistic and even behavioural, although I must admit that Carl Rogers' work and client-centered therapy was an early love of mine and that the whole approach has continued to be pivotal for me. I have not felt hemmed in by any narrow homogeneity of thinking or practice but, to the contrary, have found it a roomy, evolving and responsive system; a system that has always been alive and on the move to me. When I have found myself questioning or in disagreement with the viewpoint of some other exponent, including the founder of the system, Carl Rogers, I have felt quite free to express this difference, to debate it, and to pursue what it leads to.

Aside from my own experience, compelling illustration of the range of interests accommodated within this approach is to found in its visible products. For example, the edited volume Innovations in Client-centered Therapy (Wexler & Rice, 1974) provides striking example of variety: There is a short opening chapter by Carl Rogers, concerned with core philosophical principles. The next author, with quite different style and focus, works to carefully interpret major features of the client-centered approach within an information-processing perspective. This is followed by two meaty chapters, with 'cognitive' in their titles, drawing on main-stream psychological theory. Another chapter blends client-centered and Gestalt therapy approaches, and a still further paper focuses on "the evocative function of the therapist". One author presents theory and research on the developmental course of intensive groups; and another examines "client-centered and symbolic perspectives on social change". As these topics imply, the term "innovations" in the book title is a fitting choice. The authors move freely, linking differing thought systems and developing creative extensions in client-centered theory and practice.

A later volume, on new directions in Client-Centered Therapy and the Person-Centered Approach (Levant & Shlien, 1984), is also illustrative. One chapter re-explores and updates the concept of unconditional positive regard--"a controversial basic attitude in client-centered therapy"--and another searches into the basic meaning and forms of expression of empathy in therapy. One of the editors presents a major paper on his "counter-theory of transference". A different author than any in the first book wrote under the title "Person-centered Gestalt: Toward a holistic synthesis", and another contributor discusses a well-established programme, blending client-centered and behavioural principles, on "marital and family relationship enhancement therapies". My own chapter in this volume advances a new way of thinking about the connection between family composition and relationships and their impact on children. A paper on the personal meaning of illness examines "client-centered dimensions of medicine and health care". In a concluding chapter, Carl Rogers addresses peace and conflict issues under the heading "one alternative to future planetary suicide". Breadth and linking of thought, a search for deeper answers, and a socially urgent quest for wider application, are all reflected in the topics of these volumes.

One of the earliest and most stubborn stereotypes faced by Rogerian workers may be framed as follows, and calls for response:

Practitioners of client-centered therapy simply mirror and reflect back what the client or patient expresses.

The first part of this mistaken view is that it is no 'simple' matter to hold a mirror so that the other sees and engages with him/herself in new or clearer ways. 'Mirror', used metaphorically, is a tricky term. The good therapist is an artist whose portrait or part-sketch of the other, via 'reflection', is a characterization not a photograph, at best a likeness powerfully recognised by the client but going beyond his/her exact words and often beyond previous clear or articulated perception. Reflections in this sense may have great force and value.

The client distinctly recognising an aspect of self in the therapist's reflection or 'mirror', coupled with the therapist's attitude that such recognition by the client is the central test of whether a reflection is accurate, has long been a distinctive feature of client-centered therapy. However, the oft-presumed *exclusivity* of reflection in this approach is a second element of misconception. Reflection which is informed by full-bodied empathy remains a primary mode of response in this therapy but certainly not the only mode. Sensitive, skilled reflection is one very crucial vehicle for or 'carrier' of empathy. No presumption is made that it is the *only* way of conveying deep experiential understanding of

another person.

In the person-centered approach, it is the empathy which is considered primary and not, as might have seemed true of therapy interviews in the 1940s and into the 1950s, the reflective response as such. Images that may form in a therapist's mind, sensitive impressions or hunches that may come together from a number of things the other person has expressed verbally and non-verbally, even inquiries, questions and suggestions arising from the therapist attunement, can convey a deep and responsive awareness of what the other person is experiencing. Nowadays, one finds a variety of such channels in the work of therapists who are client-centered, although their perfection of the reflective mode is such that it still occupies rather central place.

> *Client-centered therapists believe in the virtue of therapist genuineness and honesty to the point that everything the therapist thinks or feels with the client should be expressed or made transparent to them.*

This stated view is distinctly misleading on two main counts.

Firstly, it implies that the client would desire and be able to take in such total expression by the therapist. Any of us filters, transmutes and selectively attends to signals from other people, in varying degree (as acknowledged, for example, in my paper on Listening: Barrett-Lennard, 1988). An anxious, depressed or agitated client, or a quite disturbed patient, may get a general sense that we are honest, genuinely concerned and desiring to understand, but could not possibly be expected to pick up all elements of our attitude, thinking and feeling with them. Further, it is their hour, their need, their therapy and agenda which is foremost. It is their need to heal, to become whole, to recover from symptoms that cut them off from others, to face what they deeply fear inside themselves and learn to trust in new ways. Such priorities are not consistent with therapist expression of all that flows through his/her thought and feeling.

A second consideration that renders the statement misleading is found in what the therapist is doing when occupied with a client. Our attention, as client-centered helpers, is centered on trying to understand what the other is experiencing, what their world is like to them, what the process and content of their perception is, what their struggle is like, how it must be in their shoes, seeing with their eyes, feeling with their senses, concepts, attitudes, presumptions, bearing the weight of their past and the circumstances of their present. My genuine experience and response is in large part my wanting (not demanding) to know the other, my sensing of their world and their immediate feelings or meaning, the dawning of shared knowing between us, the excitement I feel when the other's awareness is actually unfolding or shifting in some way before me. It is this whole spectrum arising from my focus and absorption with the other person that is truly and largely the substance of my experience as therapist, in company with my client.

The 'misconception' is not entirely wrong. I am, when I think about it, concerned not to mislead the other, and like to be transparent and immediate in my overt response to them. I mostly offer and share in a present and personal way when I respond, whether the form is a reflection, question, or other mode. Partly because this quality is not calculated, it seems to further the other's trust, that is, providing I *am* sensitive and that products of this sensitivity are central features of my authentic response. I say 'I' without meaning to refer only to myself but to point from my own experience to what I believe is generally true of person-centered helpers.

> *Client-centered therapists strive to respond with constant, unwavering positive regard to troubled or damaged human beings. They believe that it is generally possible and always most valuable to respond uncritically and caringly to all that the other does and is.*

This further impression/assertion and is also partly in error.

To be unconditionally responsive to the experiencing person does not mean accepting all of their behaviour and certainly does not imply condoning everything they do. It is not the other's particular actions but their self or personhood that I as client-centred therapist prize. I do not wish to critically judge or evaluate the experiencing self of the other, especially in interaction that has a personal helping goal. This is not to say that I don't warm more to some component self-systems, 'voices' or motivations within the other person than to others, but if I am not to reinforce attempted inner domination of one self and feeling system over another but, instead, to help open and free inner channels and dialogue, I need to be receptive and regardful of all the constituent 'selves' and their feelings.

Client-centered therapists proceed in the working belief that if therapists are empathic and congruent or genuine, and also positively and unconditionally regardful of the client/patient, therapeutic change will necessarily occur. No other concepts are involved in any fundamental way in their portrayal of what generates a personal helping or therapy process.

As expressed, this impression is wrong in some respects, and misleading in others.

Virtually all client-centered therapists would agree that each of the mentioned qualities or dimensions of therapist response, when properly understood, is of basic importance. On the other hand, no colleague whose thought I know well would accept that the statement as presented summarizes everything that is vitally important. It omits what many of us believeto be the most fundamental aspect of all, namely, that it is the *client's experience or perception* of the therapist's empathy, regard and so forth that influences him or her directly. The therapist could appear to an outside judge/observer to be very highly empathic and regardfully accepting and authentic, but if the client does not see and feel these qualities, or deeply mistrusts impressions along these lines that arise at some moments, the therapist's accepting and regardful understanding is to no avail. Several elements need to occur together, for example: actual empathic resonation or understanding on the therapist's part, effective communication of this responsive understanding, and the client's capacity to take it in this response and to believe that it is real, that it can be truly what it seems.

Another mistaken feature of the statement arises from the fact that further 'necessary conditions' are involved. Rogers originally postulated that the client needs to be vulnerable or anxious for the other conditions to produce change. This has not received much attention in the literature, even in Rogers' own later writing, but has never been lost sight of by the more careful exponents of this viewpoint. It follows, as I see it, that a very highly 'defended' person who is not overtly anxious, and whose vulnerability is deeply buried, would not be expected to respond to client-centered therapy. A person who is already unusually well-functioning, relatively 'fully-functioning' in Rogers' terms, probably would not seek therapy but in any case would not, in theoretical expectation, find it a means to basic self change.

There is one further condition, still, which Rogers sensed was necessary for the sake of completion, although I believe he didn't foresee the application I will mention. He proposed that therapist and client need to be in psychological contact, implying some actual awareness of each other and sense of engagement. The extremely 'decompensated' psychotic individual may for the time being have nearly lost the capacity for such contact. I believe that people rarely lose it entirely, but if the individual's experience is powerfully dominated by felt beliefs, perceptions and other signals arising internally, then their capacity for contact can be slim indeed and this would also mitigate against the other conditions actually existing in practice.

I have already indicated that the assertion statement is wrong in that it leaves out some of the vital concepts in client-centered accounts of the therapy relationship and process. I want to add just a little more. If one looks into the literature at all deeply it is soon evident that concepts beyond those already mentioned are important. First, there are principles of motivation (the actualizing tendency, for example), and other tenets of self-theory, that become very relevant if we are seeking to broadly explain recovery and development in therapy. Second, even if we simply want to describe the therapy process, the conditions model alone simply doesn't address the issue of therapy viewed as an unfolding or developmental sequence. This sequence can be seen to have a characteristic beginning, one which then unfolds into an early working process also with distinctive elements, this in turn evolving further and, finally, culminating in an ending process that differs again.[2]

Client/person-centered therapists believe that people are essentially good, trustworthy, growthful or ready to be self-actualized; full of constructive potentials which have only to be released for the individual to head strongly in a positive direction of development.

This impression contains elements of truth but is misleading in its over-simplification.

Some part of the responsibility for undue simplification can be laid at Rogers' door. He frequently said and implied that human nature is essentially constructive, that in his view people are basically good and trustworthy and forward-moving in their development, and that it is only necessary to have certain basic psycho-social nutrients present for all these qualities to show themselves and come to fruition. His most systematic writing, however, goes further and deeper than this. It carefully articulates the view, held by most others associated with this viewpoint, that an actualizing tendency or

growth principle is the primary motivating force in human life and, for that matter, using the even wider concept of 'formative tendency', in life generally and perhaps in all of nature (Rogers, 1963 and 1978).

Some exponents of this viewpoint, however, believe that an actualizing tendency is not the sole motivational principle to take seriously into account. In my perspective, it exists side by side with another principle: a tendency toward homeostasis, balance and conservation. Life and behaviour, it seems to me, hinge on both growth and preservation forces. Specific motives or needs can be viewed as varied expressions of the impetus to grow or develop, learn, expand, transcend or, the disposition to release tensions, to maintain or restore equilibrium, to heal or recover from damage, to preserve the organism or self intact.

I find it persuasive to regard flagrantly self-destructive and deliberately other-destructive patterns as being acquired, not inborn. In some sense, however, the potential for them is inborn; and the problem of evil, or of how cruelty or other extreme destructiveness arises, it not easily disposed of. I think that at base the matter has fairly close parallels, for example, with the case of integration. Most would agree that an integrative tendency, an inbuilt push to function all of one piece, is a general property of the human organism (and of other life forms), even though we find instances of extreme dissociation and many more cases where individuals are painfully divided or 'out of sync' with themselves. Similarly, a tendency to growth and actualisation could be universal but, also, vulnerable to being undercut by the intricate complexity and modifiability of our being.

> *The person-centered approach had its origin in counselling unhappy, mildly neurotic clients actively seeking help. It is of no demonstrable value with schizophrenic or other severely disturbed patients in whom (for example) delusional features, or hallucinatory episodes, are prominent.*

The first part of this assertion is misleading in its slanting. The second, main element is inconsistent with experience over the last quarter century. It does contain an issue that challenges any psychotherapeutic system.

Client-centered therapy had its origins not in the setting in which it first came into prominence but in the extensive prior clinical experience of its founder, and in the existing psychotherapy approaches he was exposed to. Most influential among these was the 'relationship therapy' innovation of Otto Rank and associated workers (see Taft, 1933; Rank, 1936/1945; and references in Rogers, 1939). During the formative development of his approach through World War 2, Rogers was as much involved in programmes for servicemen and veterans as he was in student counselling (Rogers & Wallen, 1946). And, his university-based work involved therapy with a diverse range of community as well as student clients. By no means was practice confined to unhappy or 'mildly disturbed' people, in the early years of client-centered therapy, and certainly this has not been true since. Perhaps more than other major therapy systems, the approach grew from a broad spectrum of experience and clientele.

Client-centered therapy with persons in a very disturbed or disabled state came strongly into view in the mid to late 1950s. It appears to me that the approach has had most success in achieving beneficial results in a moderate period, in the early 'acute' stages of psychotic disorder. (This may be true of depth psychotherapies generally, as well as other treatments.) There is also evidence that client-centered therapy can be valuable in resourceful, long-term application with 'chronic' patients. There are several sources for these conclusions, which illustrate the application in practice:

1. The earliest case which came to wide attention was the psychotherapeutic treatment of a mute schizophrenic woman by Dr. Louis Cholden. Interviews were superbly filmed for use in an educational TV documentary in the mid-1950s, titled "Out of Darkness". Cholden was a young psychiatrist who had recently spent a year studying and training with Carl Rogers and colleagues in the University of Chicago Counselling Centre. The film includes, for example, a remarkable sequence in which the client was finally able to borrow and use the therapist's comb. Also filmed was the occasion soon afterward in which she finally broke the "darkness" of her silence during an interview, and began to speak again. [3]
2. In the late fifties, another pioneering and still-important paper appeared. The author, John M Shlien, also trained at the University of Chicago Counselling Centre. His report "A Client-centered approach to schizophrenia: First approximation", was subsequently published in the volume Psychotherapy of the psychoses (Burton, 1961). Shlien first discussed the nature of psychosis from a client-centered perspective:

> That which we call "a psychosis" is not a disease. It is a learned behaviour, exaggerated to a point of no return....Because this exaggeration is so overwhelming, so much beyond our ordinary capacity to assimilate, it appears to us that we are no longer dealing with, for instance, ordinary suspicion, but something quite different--"paranoia". Then it appears that psychosis is not of the same order, not on the same continuum, as "normal" or "neurotic" behaviour....[The maladjustment is] so much greater in quantity that it seems different in quality too. There is one sense, unfortunately, in which it is different. A boulder balanced on the edge of a precipice can be pressed ounce by measured ounce toward rolling off. Each ounce is just like the last, but when the quantity of pressure totals to the "breaking point", the quality of the consequences changes radically. No longer will the relief or counter-pressure of one ounce recover the balance. Even if the boulder is not smashed in the fall, an enormous effort is required to restore the original position. It is because of this effort (which so few can make, and so many need) that it is necessary to prevent the "psychotic situation" in life. The "psychotic situation" is a precondition to the psychotic state, which may or may not follow (Shlien, 1961, pp. 288-289).

In a word, the psychotic situation is that of *"having an impossible life to live"*, one in which intolerable inner conflict is generated. If, out of the psychotic situation and stress psychotic breakdown occurs, the resulting therapy follows the same essential principles as with non-psychotic individuals. The principles presented by Shlien draw on self-theory and on conditions theory, with passages from Carl Rogers' own first paper explicitly on psychotherapy with schizophrenics, presented in 1958 (Rogers, 1961).

Case illustration in Shlien's paper is from the author's work with a hospitalised Korean war veteran. Three stages in client and therapy progress are carefully described. That the client improved and was discharged is a matter of record. The account given speaks not only to this (outcome) aspect, but points to rather clear steps and vicissitudes in the unfolding of the client-therapist relationship. There is no suggestion of complete healing, although afterwards the client was managing his life at home, and working again. Nor is the therapy itself seen as optimal: after all, it was an early case of its kind for the therapist and the approach. Few would read the case and doubt that it involved pioneering advance and learning.

3. In the late 1950s Carl Rogers moved from Chicago to the University of Wisconsin, as professor jointly in the departments of psychology and psychiatry; with opportunity to spearhead psychotherapy training and research in both fields. A major research programme on client-centered therapy with psychotic patients was soon under way. A early paper out of this context focused on initiating psychotherapy with 'unmotivated patients' (Gendlin, 1961). It reports an experimental treatment approach,to one side of the main research programme,in which the participating therapists worked with 24 patients in a state mental hospital. The patients were selected by two criteria only: (i) no evidence of brain damage or mental defect, and (ii) no expectation by their ward physician of discharge of transfer "in the foreseeable future".

   Therapy interview meetings in this work came about through invitation not by requirement or demand, and in most cases grew out of rapport-building contact on the ward. Only two of the 24 came immediately for consultations. For the rest, the therapists made sensitive effort to become present and known to them, within the ward milieu, to engage patiently and without imposition, and to offer private office therapy meetings. Over a five-month period, 22 of the patients came to the office for at least two consultations. Of these, 16 came six or more times. Three patients opted for over 40 sessions. The described situation at the end was that "with all but a few patients the project has reached the stage where lack of motivation as the chief problem has given way to lack of time" (Gendlin, 1961, p. 5), that is, to accommodate the patient demand for personal therapy.

4. In a 1962 article concerned with lessons from the work with schizophrenic patients, Rogers outlines a number of learnings. For example:

   > We have come to realize that almost none of the individuals with whom we have been working have ever affirmed themselves. They have never, in any meaningful way, said "I feel", "I live", "I have a right to be". They have instead been passive receivers of life's hurts, blows and events. It takes, in my experience, great patience to wait for the germination and budding of the will to say "I *am*, I deserve

> to be". Yet the phenomenon of growth is in some respects all the more exciting because it has been so long dormant (Rogers, 1962; p. 15).

Of course, there is no implication that the therapist is literally and only 'waiting'. To be inert would be to leave things as they were. The therapist's quality of listening and presence is like a radiation some of which passes through whatever wall of embattled, fearful confusion surrounds and grips the client. That which does penetrate not only reaches the suffering and divided self within but begins to soften its desperate and isolating shield. Unsurprisingly in rear view, another conclusion in Rogers' work is as follows:

> The simplest way of stating our present attitude is to say that we have learned how relatively unimportant is psychotic material. This could easily be misunderstood. The hallucination, the delusion, the bizarre language or posture has of course its significance in the psychological dynamics of the schizophrenic individual. But in the therapeutic relationship it simply forms a more difficult language of communication (Rogers, 1962; p. 15).

The language posed a special challenge but did not suggest or call for any new and different therapeutic principles. Further, the language itself tended to normalise as client stress diminished through the therapist's way of relating--as vividly seen, for example, in the case of 'Loretta'. Loretta was the code name of a hospitalized patient interviewed in situ and in turn by three prominent therapists quite unknown to her beforehand: Carl Rogers, Albert Ellis and Richard Felder. With Rogers, Loretta soon was rather freely self disclosing and exploratory, delusional and other symptoms receded, and her meanings were generally clear. Not so with the other two therapists, each quite different in approach.[4]

5. The Wisconsin programme of research on psychotherapy with schizophrenic patients finally was reported as a whole (Rogers et al, 1967). Some fourteen author-investigators and several distinguished outside commentators, contributed to the weighty volume, reporting the first major project of its kind. The study overall was ambitious and complex, the majority of patients were in 'chronic' stages of schizophrenic disorder, and the findings do not fall into any simple pattern. Various indications suggest that for the sample as a whole the therapy had beneficial but modest impact, with very wide individual variation.

   The volume includes a chapter closely illustrating the therapy itself, written by Carl Rogers and regarding a case in which he was therapist. His report (Rogers, 1967; pp. 401-416) is aptly titled "A silent young man". The transcript of two interviews, held nearly a year after therapy began, is given in full: The patient's words in total fill the equivalent of less than two printed pages! (Duration of the silences is noted.) A striking feature is the unwavering constancy of the therapist's receptivity and attention to the client's experiencing. Gentle, direct expressions of responsive interest, empathic guessing where clues are minimal, and sensitive, accurate unfolding and drawing out of the client's meaning where there is overt expression, all reveal an active reaching out quality on the therapist's part - quite opposite to the stereotype of purely reactive and neutral reflection.

   Near the end of the two interviews, the dam of the client's restrained agony finally bursts. There still are not many words but his convulsive sobbing and other expression vividly suggest that a corner has been turned, that there has been a shift or 'moment of change' as Rogers puts it, and that the future cannot simply be a replication of the past. However, there was still a long recovery path ahead. The therapy continued for more than another year. 'Mr. Brown' left the hospital in stages, resumed a course of technical or tertiary studies, found a suitable living situation, made new friends and became re-involved in the community. A quoted letter from him gives vivid example of his outlook and engagement. "As of this writing [Rogers concludes his report] he is completely on his own, functioning well, with friends of both sexes, entirely out of touch with the personnel of the hospital or the research group" (Rogers, 1967, p. 416). At the time therapy began, Mr Brown had been hospitalized for 19 months, without visible prospect of recovery.

   Before the Wisconsin report was published, Rogers had moved to California and was busy with new applications of the client-centered approach. Gendlin was again at the University of Chicago, as a professorial faculty member. Shlien was soon to develop a new Ph.D. programme, joining clinical-counselling and social dimensions, at Harvard University. Other exponents of the approach were expanding the range of practice and contributing to refinement of theory. The examples given here of work with psychotic patients are pioneering ones, from a time

when this application was a new, closely studied focus. Although such application is now much more taken for granted, it is a sphere in which particular exponents (see Prouty & Pietrzak, 1988) continue to break new ground.

This introduction to the client/person-centered approach has spanned a range of issues concerned with development, process and applications, especially in therapy. Misunderstandings easily arise around new ideas and practice, and I hope that this presentation helps to reduce some stubborn examples. Expressed positively, if the reader feels informed by the paper, or stimulated to reflect and inquire further, then its best aim will have been achieved. In character with the personal introduction, I will risk ending with a poem of my own. This connects with several of threads in my main discussion, and might draw them into further relief. I hope that my poem-picture of 'the person' evokes a sense of recognition, whether you think of yourself, someone close to you, a moderately troubled person, or one labelled psychotic. Poetry is a relatively new 'voice' for me, and it's a good feeling to find added language. That is partly why I like the poem, and share it now.

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                           A Person

One alone and many in one,
A community of I's in a Me made one
By thought, habit, a body familiar, law,
And consciousness of Other;  of you distinct
From me, each of us a singular multiplicity.

Cannot I, the person that I call me, myself,
My name -  and writing now - does not this host
Of me have many tongues, voices that argue
Back and forth not listening, opposed desires?
Do I (and you) not have a hall of mirrored selves
Inhabited or remembered within, thus still with life
And varied/repeating presence?  Are we not
As many as the seasons and settings of our lives
An abundance answering to one name,
Multiple, uncounted but counting as one?

Is it any wonder if we neglect, deny members of this company,
Leave blind a hunger, disown some voice inside or acted self;
Else risk and work, perhaps with helper, to become a one
That is not only some, not part, but all of us - befriended.
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Footnotes

1. In E. McIlduff & D. Coghlan (Eds.), (1993): Cross-Cultural Communication and The Person-Centered Approach: An International Review, Vol. 2 (pp. 99-113). Linz: Sandkorn. [As corrected & slightly amended from published copy. Originally prepared in 1988 for a seminar given in Perth.]

2. It is not feasible here to elaborate this sequence into a close account of the therapy journey, but I have portrayed it in detail elsewhere (Barrett-Lennard, 1990.)

3. The client, who became mute at the point of her psychotic breakdown, did not speak during the interviews to that stage... Sadly, Dr Cholden was killed driving cross-country to a conference after the series of interviews was filmed. One published paper in my collection, reports his thinking and work on psychotherapy with schizophrenia (Cholden, 1956).

4. I still have a large reel audio-tape copy of these interviews (and a typescript of Loretta's recorded session with Albert Ellis), which were conducted during a workshop conference of the American Academy of Psychotherapists, ca. 1961.

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