João Hipólito

Self-organisation and Complexity:

Evolution and Development of Rogerian Thinking

Organised by **Odete Nunes**

UNIVERSIDADE AUTÓNOMA DE LISBOA

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The first twelve chapters of this book were published in 2011 under the title *Auto-organização e Complexidade: Evolução e Desenvolvimento do Pensamento Rogeriano* by EDIUAL, Lisbon, Portugal. Chapter thirteen is reprinted here with kind permission from Grupo Português de Psiquiatria Consiliar / Ligação e Psicossomática.

ENGLISH TRANSLATION PUBLISHED BY
EDIUAL - Universidade Autónoma de Lisboa
CEU - Cooperativa de Ensino Universitário, C. R. L.
Rua de Santa Marta, n.o 56 — 1169-023 Lisbon
Portugal

COVER
Miguel Pereira

DESIGN | LAYOUT
EDIUAL

ISBN
978-989-9002-04-3

REGISTO CIP

Hipólito, J. (2019). *Self-organisation and Complexity: Evolution and Development of Rogerian Thinking*. Lisboa: EDIUAL.

CDU 159.9
316.6

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Acknowledgements

This book developed through years of reflection, conferences, presentations and articles written, often in the wake of seminars I held or supervised. It also incorporates all that I have learned, my training to become a Client/Person-Centred psychotherapist, my encounters with Carlos Caldeira at the beginning of my career, the professional growth I achieved through my interactions with Carl Rogers, John Shlien, Barbara Broadley, Nat Raskin, Fred Zimring, Natalie Rogers and other masters and colleagues, all of whom enabled me to become the person I am today.

I cannot, however, fail to mention those who during my training in psychoanalysis, later abandoned to reencounter my true self, taught me *tools* which, re-examined from a Client-Centred perspective, not only became important but essential instruments for my professional practice. My thanks go to Madeleine Rambert, René Henny, René Diatkine, Michel Sapir, Edmond and Micheline Gilliéron, Hubert Auque, Paul Lemoine and Luc Kaufmann, among others.

Younger colleagues have also encouraged my thinking to reach new levels of depth over the years, by their reflections and queries. My profound thanks and deep appreciation to Odete Nunes, Fernanda Santos, Marco Paulino, Francisco Moniz Pereira, Guimarães Lopes, Anne Marie Marin-Blanc, R. Laroche, Michel Voirol and, from a more recent time, Rute Brites, Mónica Pires, Tito Laneiro, Paula Pires, Ana Ribeiro, Brissos Lino, as well as to the colleagues from the psychopathology seminars I held in Paris. Special thanks to Lucília Tibério for the meticulous care she took on proofreading the original, Portuguese text.

There can be no doubt, however, that this book could never have been published without the insistence of my wife and colleague, Professor Odete Nunes, who took on the tedious job of collecting, collating, coordinating and correcting the countless documents underlying this book. Without her unwavering commitment, we would be left with nothing more than a scattering of documents, shared experiences and the memories of those who have stood by me on this journey over the years.

My thanks also go to Martina Nitzsche for her excellent work in translating the original Portuguese text, for thoroughly checking its accuracy and making any necessary corrections in terms of language, citations and references.

I would also like to thank Professor Isabel Leal for her kindness in writing the foreword to this book. Over the years, she has been a friend and a colleague who, despite our following different theoretical

models, has always attached greater importance to the friendship we share and the respect we have for one another.

Lisbon, 17th of July 2009

João Hipólito

Foreword

Beyond all the origins, which enable us to trace the history of a concept and help us to realise that all major breakthroughs, as novel, creative and innovative as they may seem, are indebted to the past, Psychology, which has always been a feature of human life and with important texts in classic literature, had to wait for the 20th century before it could step out of the shadows and establish itself as a science and a profession.

One of the most important names to emerge from this revolution in the world of knowledge and so-called human sciences was that of Carl Rogers. Considered by some as the most important psychotherapist of the 20th century, by others as the most influential psychologist, I am tempted to say that it was necessary to wait for him so that Lightner Witmer's 1896 statement, on what clinical psychology should be, could finally take shape.

Indeed, until then, clinical psychology, intending to oppose laboratory practice by working in a decidedly practical and socially-committed manner, was merely a project-in-the-making, given that the work carried out by psychologists in this domain was almost exclusively limited to taking measurements and making diagnoses. Psychotherapy belonged to psychoanalysis, a closed European model

which was embedded almost exclusively within the confines of the world of psychiatry.

It is to Rogers we owe that which today seems to be consensual among clinical psychology practitioners the world over: that psychotherapeutic intentionality is present in psychological intervention, that is not simply a matter of using techniques which work, but of knowing when and how to use them, by taking into consideration the context and the real person involved in the relationship, and by always adopting a philosophical stance which, in principle, will enable the person to express his or her own worldview.

Rogers' proposals, which were developed for a wide range of situations: psychotherapy, training, education, centred on individuals as well as on groups, continue to be surprisingly modern in this day and age.

Indeed, unlike other perspectives that were either developed specifically for unique situations or over the course of decades by successive generations of psychologists or psychotherapists, Carl Rogers' model is, in itself, an organised structure, accessible and a flexible means to access the Other and the world under any circumstances.

His non-directive perspective, drawn from the personal and professional experiences in his life, was at that time, and still is today, truly revolutionary, because it strips models and institutional power of their transformative capacity. While not intentional, by seeing the Human Being as a totality, interacting as a whole with the

environment, with his or her self-actualising and self-regulating tendencies, he allows the person to direct his or her own life and reorganise his or her Ego. In this sense, he was a precursor of the current notion of personal responsibility, rather than someone who adopted the reigning perspective of his time, that of the individual devoid of resources, on whom external forces and powers are exerted which, under the guise of "scientificity", are more objective, correct or effective.

From his non-directivity, reflected in his refusal to guide or impose a specific direction within the scope of his interventions, emerge the principles underlying person-centred psychotherapy, given that the therapist's overarching attitude is based on trust in the client's capacity for self-direction, in line with the humanist philosophy subscribed to by the therapist, and which generically considers that the individual is able to consciously experience his or her psychological maladjustment.

His extensive, brilliant and fascinating work marked a generation, and within the human sciences it launched a movement which continues to spread and gain followers around the globe, despite the fact that, for most of his life, Rogers was reluctant to institutionalise his own "School".

Nevertheless, in the sixties, his work and thinking arrived in Portugal.

The book that Professor Hipólito now presents us with, begins precisely by acquainting us with the circumstances of the time and

with the people who introduced us to the work of Carl Rogers, a time when the country was still closed off from the world and where the ideas, books and the dynamics of highly motivated small groups were a precious source of intellectual stimulation and emotional and social awakening.

He declines to talk about himself, about his role in this truly formative movement which for some of us represents but a brief moment in time, whereas for him it marked the beginning of what is already an extensive professional career, firmly intertwined with the thinking of Carl Rogers.

The book he now places at our disposal, begins by recalling this historic time, continuing thereafter, chapter by chapter, by elaborating the ideas underlying this perspective. First in a more general manner and then in greater detail on the developments and practical applications which Rogers' model and the experience, skill and art of Professor João Hipólito, himself, have enabled over the years. Reference is made, on the one hand, to specific contexts such as families, groups and therapeutic communities and, on the other, to techniques from different backgrounds which have proved useful in therapeutic work and compatible with the centred approach, such as psychodramatic techniques or body relaxation approaches.

Long awaited, this book enhances what Rogers himself has written, the unique and remarkable experience of a man who, in his capacity as a professor, psychotherapist, trainer and supervisor, has

taken on the enormous and difficult task of maintaining alive and actualising the meritorious thinking of Carl Rogers.

Belas, 13th of September 2009

Isabel Pereira Leal

Chapter I

The Person-Centred Approach in Portugal

It was in 1967 that Carl Rogers' thinking first began to spread in Portugal, thanks to some Portuguese psychiatrists who had come across his ideas in French works, namely Pagès' *Non-Directive Approach* (1965/1976) and an article he published in *Encyclopédie Médico-Chirurgicale* (1968). Later, Caldeira and Lalande, both psychiatric assistants at the Faculty of Medicine in Lisbon, were able to access works written by Carl Rogers himself.

At that time, in Portugal, the world of psychiatry was highly influenced by German philosophy, the ideas of which greatly contributed to the development of Anthropology, and Medical Anthropology in particular. Caldeira and Lalande were impressed by Rogers' thinking, both in terms of its existential philosophic nature and its commitment to social psychiatry.

Subsequently, Carlos Caldeira wrote a number of articles which enabled Rogers' thinking to spread. In 1972, the Portuguese edition of Rogers' (1970) book *On Encounter Groups* was published, having been translated by Lalande. It is significant that this was the first title chosen for translation, as it is indicative of the concerns felt

by a group of individuals interested in community psychiatry and group work.

In 1968, Caldeira went to Brazil to teach psychopathology at the University of Amazon. There, he was confronted with a very serious social problem, that of the poor, even more neglected than those in Portugal. In the summer of 1969, for personal reasons, Caldeira returned to Portugal and became head of a university hospital psychiatric service. It was at that time that we began to work together; as a voluntary intern at that hospital, we were able to establish a relationship through my work.

The conditions at work were dreadful. The Julio de Matos Hospital in Lisbon had been built with an open mind and was, at the beginning of the 20th century, a prestigious institution. However, in 1969, it almost lay in ruins, despite being considered the leading hospital within the sector. This sector was subdivided, and our team was responsible for an underprivileged, semi-urban area resembling a slum.

In terms of team members, absenteeism and the need to work a second job in order to survive substantially increased nursing staff workload and, simultaneously, reduced the effective attendance of health care staff in the therapeutic space.

This situation embarrassed Professor Caldeira, because despite the fact that he lacked the resources to carry out his work he felt deep concern for others and their personal development. He was

truly committed to using Person-Centred Approach principles in individual therapy, group therapy and pedagogical training.

At the end of 1969, and as a result of his endeavours, a therapeutic community was created at the hospital. Although he was clearly inspired by ideas underlying the Person-Centred Approach, still known as the Non-Directive Approach at the time, Caldeira staged a novel intervention in the scope of his work with this community. Everyone from the psychiatric unit was invited to participate in the first session, from auxiliary staff to the full professor, to patients. The community was created with the full awareness that the people who came, those who were interested, would ask themselves what they were going to be doing there. There was general agreement that they wanted to fundamentally change how they functioned and their way of being, but could not count on any help, namely additional resources or external support.

Some time after the therapeutic community began functioning at the hospital we started to observe some significant results, such as lower absenteeism and a significant increase in therapeutic efficacy (lower relapse and suicide rates and shorter treatment periods).

Although the therapeutic community was working well, it gradually became clear that working with the patients at the hospital was not enough. The journey to and from the hospital meant that the patients had to make themselves available for half a day, which had a negative impact on their salaries.

In an attempt to resolve this situation, Caldeira (1979) and his team relocated to the centre of the slum where they gave "mobile" consultations and delivered medicine to patients. As the team was made up of only a few members, it was unable to attend to all potential patients, leading the technicians to opt for a group consultation. Thus, all new patients were first seen individually and then asked to join the group consultation. The few patients who refused to participate in the group consultation were seen at the hospital, as there was no alternative.

Caldeira quickly realised that individuals, and the group, felt "disembodied" whenever removed from their social environment. Caldeira witnessed the deplorable conditions in which these people lived, people who were being given access to psychotherapy (generally free of charge or for a symbolic price), who made progress as certain symptoms disappeared, but who became even more despondent whenever they were deprived of the symptom or symptoms enabling their survival. That is, by treating the patients as real people, they abruptly and dramatically became aware of their harsh social reality. In light of this, in addition to maintaining its interest in individual or group therapy, the team took an interest in social intervention. The question was: what could be done in terms of the environment in which these patients were "surviving" rather than living?

After much consideration, the team was able to see that, on the one hand, while Rogers' ideas and the philosophy underlying the "Person-Centred Approach" enhanced each of the team members,

providing them with a tool that helped them to work or reflect on their way of being in the relationship and on how to intervene, it did not, on the other hand, afford them the means to intervene under these conditions, in this slum, in direct confrontation with the world of social politics.

Thus, on considering the economic, social, architectural and political implications of the situation, the people involved in this project tried, for example, to locate the community's decision makers. Slowly but surely, an analysis was carried out of the world of those living in the slum, no longer from an individual or small-therapeutic-group perspective but from one that took into account the people's natural environment, including all social factors inherent to their living conditions, such as work or unemployment.

This analysis, necessary for the continuity of the intervention, made the team realise that it was approaching the person not only as a unique being, but as a being who was part of more than one system, that is, a complex system within other, larger systems. At the time, systems theory had not yet become widespread, and our stance had obviously nothing to do with our wanting to be "ahead of the game", but the technicians were eager to understand why the patients, who seemed to be improving from a psychiatric perspective, remained in or reverted to a state of despair. The team was forced to recognise that despite its best intentions it was playing God and that desire alone was not enough to help these people.

Thus, slowly but surely, the team realised that it needed to prepare itself for the intervention, a preparation based on attitudes of attentiveness, empathic understanding and unconditional positive regard. Indeed, working in an underprivileged neighbourhood meant that technicians had to demonstrate a high degree of acceptance, without becoming incongruent, throughout the intervention. As a result, the following question surfaced: how to, on the one hand, live a relatively comfortable bourgeois life and, on the other, intervene in a context where the people did not have the most basic requirements?

Recognising the need to complement its training in Rogers' approach, the team set out to expand its knowledge of areas of the Human Sciences that would provide for a better understanding of the so-called socio-anthropological "systems", which take into account the person's natural environment.

Team members were active on a number of fronts in the wider geographical area (e.g. schools, families, information centres, residential committee, clubs and local administration), allowing them to establish links between the mental health community they wanted to help establish and the groups and organisations that already existed in the wider geographical area. It should be noted that our intention was not to *psychiatrise* but to avoid the marginalisation of the "crazies", by promoting the participation of everyone in the wider geographical area in the primary prevention of mental illness. The team developed two different vantage points, the first based on an attempt to understand the patient by "seeing" the person from his or

her subjective point of view, that is, as a person concerned with him- or herself within the world in which he or she lives, whether that world be personal, family-based, work-related or political. In Client-Centred Approach interventions these worlds can be revealed to the therapist through empathic listening.

Unlike the "internal" or "subjective" perspective of our first vantage point, our second vantage point was based on an "external" perspective, one supported by knowledge from the Human Sciences. The team was made up of doctors, nurses, social workers, economists, urban planners and teachers, each possessing a specialised body of knowledge. Although myths surrounding professionals are often dispelled in their work with the population, we believe it is inconsistent to tell people who are seeking our help that "we do not know anything", because it simply is not true. In addition to our commitment to a person- and/or group-centred intervention, specific knowledge is available in History, Sociology, Economics, Psychology and Psychiatry.

The subjective view of the patients and the relatively objective view of the professionals on the team can be thought of as two sides of the same coin, two points of view that can never completely coincide but that complement each other in the building up of a system which, without intending to replicate the real person, comes as close as possible to the real person with every new step. The two aspects can be seen as a quantum pair, complementary but irreducible, behaving in accordance with Heisenberg's uncertainty

principle, in the spirit of the "Copenhagen interpretation", on uncertainty, complementarity and disturbance of the system by the act of observation. The art in this type of intervention lies in understanding this irreducible difference, a difference one knows to be irreducible despite attempting to reduce it.

In Portugal, in the late sixties, when this first community was formed, it seemed to us that Rogers was still far removed from any social concerns. Although he was interested in encounter groups and education, he gave no indication of having come across Paulo Freire (1968/1974). Rogers had begun to take an interest in European existentialism, but, to our knowledge, no social cause had as yet been addressed by him in his writings.

At that time, the Portuguese found themselves embedded in a very complex social environment and felt the need to re-examine and build on Rogers' ideas so that their needs and social concerns could be accounted for.

By creating, developing and analysing the theoretical model known as the socio-anthropological system, Caldeira (1979) provided a solution to an indisputable socio-cultural concern, introducing a new theoretical perspective that greatly enhanced and influenced the development of the Person-Centred Approach in Portugal. In Chapter X of this book, where we discuss the application of this model in the treatment of drug addiction, we expand on the model's characteristics and underlying implications.

According to Caldeira (1979), while science can only exist in abstract and general terms, the human being is a concrete and unique entity, who has a history and is embedded in a complex web of relationships comprising countless irreducible aspects, an open system that is constantly evolving and in permanent interaction with other systems, that becomes by doing, a physical presence in the here and now of the encounter.

Thus, it seems to us that "knowledge" of what it means to be human can only be captured from the concrete human being, the person who has a past, is living a present, and who faces a future that he or she determines despite numerous constraints, often having to endure pain and suffering.

A human is born as "potential-to-be", actualising through the formation of the body, a biological body, a diachronic materialisation emerging over time. This body, an objective reality to the extent that it can be touched, is the result of a long process that is not only biological but also psychological, cultural and social, among others. As a body of systems in interaction, it is a system unto itself and, simultaneously, a subsystem. But the human being is more than just a body, he or she is a Person, a whole person with the *totalising* capacity to give meaning to the world, to name the world, a socio-anthropological system positioned at the crossroads of the diachronic and the synchronic, the singular and the collective, a world unto itself of meaning, understanding and purpose.

When analysing a socio-anthropological system, or more precisely when studying a system or dimension of analysis, the objective is to discover how the person perceives him- or herself and his or her world and then compare this with the perception the external world has of the person, attempting to analyse and reduce the discrepancy between these two vantage points: the "being-in-itself" and "being-for-itself" of the socio-anthropological system; two complementary but irreducible perspectives, as in the two sides of the same coin.

A dialogical interaction analysis which is based on the principles of the Person-Centred Approach can facilitate the actualisation of the socio-anthropological system's evolutionary and maturative potential and capacities. Szent-Györyi (1977) refers to this as the manifestation of "syntropy", to Whyte (1974) it is the "morphic tendency", and Rogers (1983) calls it the "formative tendency" inherent to all elements of the universe, a process which opposes entropy or, in the language of Freud (1978), Eros opposing Thanatos.

By centring the intervention on the person, by respecting the person's defensiveness and his or her own rhythm, "conscious" or "unconscious" censorship can be overcome, allowing the person to feel safe and able to integrate experiences and feelings hitherto censored.

Thus, by listening to the other person and his or her discourse without prejudice or judgement one avoids reducing the person to a preconceived model of some ideal.

The other person *Is* and *Will Be* for and in His or Her self, and if there is to be model then it must to be that of *Being*, being as a totality, in a new-found freedom of *Being*, from one's self, meaning the world of values and criteria that one by one the person determines as most appropriate for him- or herself, that is, the person's own set of values.

The Person-Centred Approach helps us to understand the meaning of the client's discourse, careful to avoid contaminating the client's discourse by introducing our own (technician's) meanings. The technician may be the facilitator of change, but the locus of choice and decisions or evaluations always resides within the other party, whether the other party be an individual client, a group, a patient or a student.

A relationship-centered dialogical approach can help us to gain a partial understanding of the perception and significance of a person or group in relation to a system or object, by seeing the person from within his or her world, whereas information on the "objective reality" can be collected through methods in the human sciences. Although this two-fold perspective is indispensable for understanding and analysing a socio-anthropological system, we should never lose sight of the fact that when it comes to *humans*, the subjective view takes precedence over the objective view.

It can be said that no one is more familiar with A's world than A him- or herself. Experience and science might allow us to predict A's behaviour in situation B, but it is imperative we always remain open to

"awe" and the unexpected, always leaving room for some "miracle", for the "exception to the rule", an exception that probably is the "rule itself".

The Gospel of Matthew states that: "If your right eye causes you to stumble, pluck it out and throw it away from you" (Matthew, 5:29). From this, we can infer that if our understanding of the Other is clouded by our own experience and theoretical knowledge, then it becomes impossible for us to move around delicately within the other person's world without judgement or criticism, without trying to mould the person or steer the person away from his or her own process of becoming. Thus, it is better to cast aside our knowledge which has become a form of pseudo-enlightenment, a tool for manipulation and enslavement, and not *Sophia* or driver of freedom.

At the personal, interpersonal or group level, the Person-Centred Approach is a therapeutic approach encompassing a diverse range of specific techniques such as individual therapy, group therapy (e.g., therapeutic groups, family groups) and brief therapies, favouring a verbal strategy or one that is analogue, as in the case of relaxation therapy or psychodrama.

Regarding groups, organisations and institutions, the Person-Centered Approach can help to build communities, centred on freedom and liberation, and create new relationships in which diversity and individual differences are respected. Examples of this are therapeutic communities, communities based on a common interest and pedagogical communities in which learning is a two-way process

based on dialogue, in which education is a liberating process and not a tool for oppression. "Knowledge" is appropriated through personal experience and not through experience described and conveyed by others. In this sense, contrary to being a system based on "making deposits" in abstract human beings, education and learning represent freedom, one in which the focus is on the real human being, the person in relationship with the world. A learning within freedom and of freedom that rejects the treatment of others as ignorant objects; a learning that, rejecting manipulation, conquest, division and cultural invasion, is based on cooperation, unity, organisation and cultural synthesis; a learning facilitated by those who do not think of themselves as an enlightened elite, there to educate the ignorant, teach freedom to the oppressed and propose new models of "already-existing-communities", but who liberate themselves at the same time as the community liberates itself, who learn from the community a new way of being-in-the-world and, thus, become full members of a community of free people.

The Person-Centred Approach provides organisations or institutions in crisis with a means by which groups and institutions can find and establish new ways of being, new ways of relating, based on mutual respect, valuing individual differences and diversity, love, unconditional positive regard, that is, alternatives to oppression, discrimination, hate and destruction. To create structures that generate love, from apparent chaos, rather than creating chaos by imposing indulgent and deadly structures that generate hatred.

Rogers was often accused of being naive, overly optimistic and somewhat delusional. The Person-Centred Approach, as an existential philosophy of life, a "way of being", an approach that focuses on the relationship, the person, the group, the community, is subject to the same type of criticism.

But, without roots there can be no utopia. Among humans beings, these roots are Love, personal commitment and freedom, without which there can be no community, no Humanity. Fear generates suffering. There is no fear in love, on the contrary, perfect love drives out fear (1 John, 4:18).

Chapter II

Carl Ransom Rogers' Contribution to Psychology

Krischenbaum and Henderson (1990) published a book containing a selection of texts written by Carl Rogers which they called *The Carl Rogers Reader*. In the introduction to this compilation of texts, one reads that: "Carl Ransom Rogers (1902-1987) was the most influential psychologist in American history" (p. xi). This statement has become an absolute truth for those affiliated with the worldwide Rogerian movement, because it is written in a highly acclaimed scientific book! However, as Kirschenbaum himself points out in one of the articles in the publication, this statement contains a mistake because the exact text reads: "the most influential psychotherapist in American history" (Smith, 1982, cited by Wood, 1994, p. 1).

Kirschenbaum based himself on a study by Smith (1982) published in the *American Psychologist*. Smith had conducted a survey among 800 psychologists, members of the Clinical Psychology and Counseling Psychology Divisions of the American Psychological Association. In this survey, although eclectic therapy proved to be the most widespread of all therapies, it was Carl Rogers who headed the list of figures who had had the most impact on therapy and

counselling. In Warner's (1991) study among 80 Canadian university counsellors, published in the *Canadian Journal of Counselling*, the Person-Centred Approach ranked in second place behind eclectic therapy, and one place ahead of cognitive-behavioural therapy. Once again, Carl Rogers was named as the most influential therapist.

Kaplan and Sadock (1995) also referred to Carl Rogers as having probably been the most influential theorist in the field of humanistic personality theories.

Even if Rogers was not the most important psychologist of his time, as considered by Wood (1994), nor the most influential psychologist but only the most influential psychotherapist in American history, there can no doubt that he, as a person, and his work made a lasting impression not only on American psychology and psychotherapy but on psychology and psychotherapy in general.

It is worth mentioning that Rogers published more than 250 articles and about 20 books – on his own or in collaboration with others. Also, some 12 films were made of his work, leaving us with a considerable volume of audio and video footage showing us how he worked.

It is impossible to avoid the work and ideas Rogers developed within numerous areas of Human life, and it seems safe to say that every psychologist, psychotherapist or educator of every school or theoretical orientation has, at some time or other during his or her training, come across his writings or some reference to his work.

Whether it had to do with a non-directive approach in psychotherapy, client-centred therapy, person-centred approach, student-centered learning, encounter groups, human resource or business management, or with the mediation of social, political or racial conflict, his activities over the span of his life were fully devoted to freedom and unleashing the forces which enable Human Beings to actualise their potential.

Carl Rogers' Journey Through Life

In order to appreciate Rogers' work and his contributions to the understanding of Human Beings, in general, and to the advancement of psychology and psychotherapy in particular, we need to look at his background, at the story of his journey through life. This journey would come to define him, his existential outlook on life and his faith in the ability of Humans to achieve freedom and determine their own future.

Carl Ransom Rogers was born on the 8th of January, 1902, in Oak Park, on the outskirts of Chicago. With four brothers and one sister, he was the fourth child in a family of six children. He died in La Jolla, California, on the 4th of February, 1987, after sustaining a hip fracture. As per his instructions, the machines which were "artificially" keeping him alive were switched off after three days in a coma.

His parents, both university-educated, were members of a protestant community with strong religious convictions. The family

valued a moral and religious upbringing, steeped in traditional values, and was quite strict about matters of a sexual nature. Although the family kept to itself, the atmosphere at home was intellectually stimulating.

Rogers took an early interest in reading and "knowledge". He was an exceptionally bright student and always helped around the house, meaning that his social life was reduced to a minimum; that is, the extreme emphasis placed on physical or intellectual work did not give him time to pursue any leisure activities save reading classic literature, preferably that of a religious nature.

When he was 12 years old, his father bought a large farm on the outskirts of Chicago to where the family moved, the official reason being to conduct "scientific" agriculture. According to Rogers, the real reason was to keep the children away from the "dangers of city life". Life on the farm and his work in agriculture led him, in 1919, to enrol in Scientific Agriculture at the University of Wisconsin. He got involved in a number of community activities, honing his skills as "facilitator" and organiser. He came into contact with militant evangelical groups and decided to change his course to History, the intention being to devote himself later to a career in the ministry.

In his third year at university he travelled to China as part of an American delegation to participate in the World Student Christian Federation Conference. The journey lasted six months, a time during which he abandoned some of his religious convictions and opened himself up to a diversity of ideas and views. Upon his return to the

United States, he felt a new sense of autonomy and freedom from the opinions and positions held by his family, although it was at this time that he also developed a duodenal ulcer, probably resulting from the process of his becoming more assertive.

Nevertheless, he remained determined to become a pastor, to become involved in social and political causes, trying to demonstrate the incompatibility between Christianity and war by, according to Kirschenbaum (2007), writing about Wyclif's pacifism or Luther's position on authority.

In 1924, Rogers completed his degree in History and married his childhood friend, Helen Elliot, with whom he had two children: David, born in 1926, became a doctor and was later appointed head of the Medical Faculty at Vanderbilt University; Natalie, born in 1929, developed an expressive arts therapy and worked with her father in the organisation and development of workshops for small and large groups, which sometimes brought together hundreds of people.

After earning his degree in History, Rogers applied to Union Theological Seminary in New York, known for its "liberal" theological stance, yet highly regarded from an academic point of view. He refused the financial aid of his father, Walter Rogers, proposed on the condition that he enrol at the Princeton Seminary, an institution considered far more conservative.

During his first year at the institution, Rogers had the opportunity to attend some courses at the Faculty of Psychology where he came into contact with Watson (1971) and Kilpatrick (1951),

two psychologists who made a great impression on him. With the help of some of his colleagues, Rogers organised a seminar on self-facilitated reflection and ended up coming to terms with his lack of vocation for the ministry, despite, that summer, going on to complete an internship as substitute pastor in the parish of Dorset, Vermont. Thus, in his second year he transferred to Teachers College, Columbia University, to study Clinical Psychology and Psychopedagogy. There, Rogers was struck by the philosophy of Dewey (1939/1973) who, without doubt, had a major impact on the development of his ideas. In the meantime, to provide for his family, he continued to work with clerical institutions, teaching religion.

In 1926, he was accepted as an "intern" at the Child Guidance Institute, recently established by the Community Fund of New York. After being given his contract which stipulated an annual salary of 2,500 USD, it was suggested to him that his salary be halved, given that he was a psychologist and not a psychiatrist. Therewith began his "war" with psychiatry, though he did eventually manage to secure the same salary as that of a psychiatrist. At the institute, Rogers will have come across one of Freud's disciples, and dissenter from psychoanalysis, Alfred Adler, who does not seem to have had any particular impact on him.

Rogers earned his Ph.D. from Teachers College in 1931. Within the scope of his thesis he developed a personality test for children which is still used nowadays, something we were able to confirm during our review of the literature for this book. In 1928, as a doctoral

student, he went to work as a psychologist at the Child Study Centre of the Society for the Prevention of Cruelty to Children, in Rochester. He became the director of the Centre in 1929, and for a period of 12 years his interests were focused on working with delinquent and underprivileged children. At the institution he came into contact with Otto Rank and it was Rank's therapeutic practice, more so than his theories, that made an impression on Rogers. Without doubt, his greatest source of influence came from Jessie Taft who, in 1933, published the book *The Dynamics of Therapy in a Controlled Relationship*, regarded by Rogers as a masterpiece, both in terms of its approach and its literary content. Rogers gradually stopped using a directive or interpretative approach, opting for the more pragmatic approach of listening to his clients, which ended up being the foundation block of what would later become the non-directive approach in therapy.

In 1935, he began to lecture at Teachers College, but felt that his work as a professor and his status as a psychologist were not given the recognition they deserved by the faculty's Psychology Department. Only much later, after years of being a professor in the Sociology and Psychopedagogy departments, and when he was about to leave Rochester, did the Psychology Department recognise him as both a psychologist and a professor.

In 1938, he once again went to "war" against psychiatrists. The Centre, which he ran and was working at, was undergoing a process of change and expansion. However, the Board of Directors, under

pressure from the psychiatrists, decided, as was the tradition at the time, to hire a psychiatrist as the new director, despite the fact that they were pleased with the work that had been accomplished thus far. Having fought hard, Carl Rogers successfully became director of Rochester's new Guidance Centre.

In 1939, he published his first book, *The Clinical Treatment of the Problem Child*, in which he presents the essentials of his ideas and the research that had been carried out by that time.

This book helped to promote his reputation as a clinical psychologist and he was invited to become a full professor at Ohio State University, where he came to be responsible for the "Psychotherapeutic Techniques" programme. Without omitting the most important models in psychotherapy and counselling, Rogers had the opportunity to describe his own therapeutic approach, regarded by him as "newer" therapy that, in comparison with "older" therapies, focused on expression, self-acceptance, awareness and the therapeutic relationship, rather than on analysis of the past, suggestion or interpretation.

During his time at Ohio University, Rogers introduced into the curriculum the teaching and practice of psychotherapy, and supervision thereof, and he also developed an innovative method for investigating therapeutic processes which involved recording entire interviews and complete therapy sessions.

Gradually, and in a practical manner, he developed an intervention method that was increasingly non-directive, using a

"checking perceptions" technique (Rogers, 1999), based on an attitude of heightened acceptance of the client's feelings on the part of the therapist.

Rogers was unaware of the uniqueness of his thinking until he was confronted with the reactions to his conference at Minnesota University, on the 11th of December, 1940. In his conference, which he called *New Concepts in Psychotherapy*, he claimed that: "the aim [of this newer therapy] is not to solve one particular problem, but to assist the individual to *grow*, so that he can cope with the present problem and later problems in a better-integrated fashion (....) In the first place, it relies much more heavily on the individual drive toward growth, health, and adjustment (....) In the second place, this newer therapy places greater stress upon the emotional elements, the feeling aspects of the situation, than upon the intellectual aspects (....) In the third place, this newer therapy places greater stress upon the immediate situation than upon the individual's past (....) This approach lays stress upon the therapeutic relationship itself as a growth experience" (1942, pp. 28-30).

Criticised or appreciated, he did not leave his listeners indifferent, and he became aware of the fact that his position on therapy was quite unique. Rogers stated that: "It may seem absurd for someone to nominate the day on which client-centered therapy was born. However, I feel it is possible to nominate that it took place on the 11th of December, 1940" (1964, cited by Kirschenbaum, 1995, p. 17). This date has since then been considered by the Rogerian

movement as the foundation date of the movement, or perhaps it would be fairer to say: the "mythical foundation" date of the community.

Carl Rogers then went on to prepare a more detailed and systematic account of his therapeutic approach which was published in his 1942 book, *Counseling and Psychotherapy*. There was increasing similarity between the concepts of "counselling" and "psychotherapy", and between the concepts of "non-directive counselling in therapy" and "client-centred therapy". The book itself was innovative, as it was the first time that the transcripts of a complete treatment process had been published. The book was a success and became a bestseller, though it did not catch the attention of the scientific journals specialising in psychiatry and psychology.

While, on the one hand, Carl Rogers was the recipient of official recognition and honours — he was elected vice-president of the American Association of Orthopsychiatry and president of the American Association of Applied Psychology — on the other, there was a certain amount of ambivalence towards him among the institutions, one expressed by a lack of support and a feeling of being excluded which, at a certain point in time, he was confronted with at his university.

So when, in the summer of 1944, he was invited by Ralph Tyler to teach psychology at Chicago University and set up a new Counselling Centre there, Rogers accepted, leaving behind him a group of disciples, some of whom have spearheaded the Person-Centered Approach,

such as Combs (1946), Axline (1947), Raskin (2004), and Gordon (2004), who blazed new trails by putting Rogers' ideas into practice.

The setting up of this Counselling Centre was another stressful experience for Rogers, given the tension it created between him and, this time, the university's Department of Psychiatry.

The period between 1945 and 1957 was a very gratifying time for Rogers from both a personal and a professional perspective. It was during this period that he published an extensive volume of work, chief among which was the book entitled *Client-Centered Therapy* in which Rogers, along with his colleagues, provided an update on the status of his research and thinking.

He went through a time of deep suffering in the years between 1949 and 1951. After experiencing moments of extreme difficulty during psychotherapy with a schizophrenic patient, he went into depression, causing his ability to work and function properly to become severely compromised. He eventually accepted the help of one of his disciples, Ollie Bown, with whom he underwent therapy that helped him to overcome his difficulty. He was able to experience firsthand the effectiveness of his own model, a "labour" from which he emerged more mature and that marked the beginning of a long journey towards personal "growth", a journey he was never again to abandon.

Finally, we can say that his professional contributions were openly recognised, given that he was elected president of the American Psychological Association (1946), of the newly-formed

American Academy of Psychotherapists (1956), and, in 1956, awarded the Distinguished Scientific Contribution Award by the American Psychological Association (APA)

> (...) for developing an original method to objectify the description and analysis of the psychotherapeutic process, for formulating a testable theory of psychotherapy and its effects on personality and behavior, and for extensive systematic research to exhibit the value of the method and explores and test the implications of the theory. His imagination, persistence and flexible adaptation of scientific method in attacking major problems concerning the understanding and modification of the person have moved this area of psychological interest within the boundaries of scientific psychology (APA, 1957, cited by Kirschenbaum, 1995, pp. 34-35).

The pivotal aspect of his approach involved the gradual shift in emphasis from techniques to attitudes, that is, from the technique of reformulation to attitudes of empathic understanding, acceptance of the client, congruence of the therapist, trust in the client's abilities — for self-actualisation and self-organisation — and appreciation of the therapeutic potential of the relationship.

It was also an intense time in terms of research, a time during which more than 200 investigations were carried out and thousands of therapy sessions were recorded and analysed. One of his principal articles, *The Necessary and Sufficient Conditions of Therapeutic Personality Change*, was published in 1957. This article continues to be one of the pillars of the Client-Centered Therapy model and it has stimulated an important body of research.

Rogers enunciated the hypothesis, considered by him to be comprehensive and non-exclusive, of his personal approach to therapy in the following way: if two persons are in psychological contact; if the first person, the client, is vulnerable or anxious; if the second person, the therapist, is congruent, or integrated in the relationship; if the therapist experiences unconditional positive regard for the client; if the therapist experiences an empathic understanding of the client and of his or her internal frame of reference; if the client becomes minimally aware of this congruence, acceptance and understanding, then the client will experience positive therapeutic change.

Rogers started to become well known and he was invited by a number of universities to lecture as a visiting professor, namely UCLA, Harvard, Berkeley, Brandeis and, in 1957, the University of Wisconsin's Department of Educational Sciences, where, after a few months as a visiting professor, he ended up staying.

In the seven years that Rogers spent at this university, he and his team conducted an enormous amount of research on psychotherapy with schizophrenic patients, the results of which are

published in the 1967 book, *The Therapeutic Relationship and its Impact*. His relationship with the Department of Psychology was not very satisfactory and he eventually left in 1963, though he continued his work, on an exclusive basis, at the university's Department of Psychiatry.

This turned out to be one of the most difficult periods of his professional life. Friction surfaced between team members that almost destroyed their work. One of his collaborators, Charles Truax, was involved in activities which Rogers considered ethically problematic. Rogers was initially reluctant to separate himself from Truax, but he did so later on when irreparable damage had been done to both the research program and the team atmosphere. Truax, a victim of mental illness, ended up committing suicide some ten years later.

In the summer of 1961, Carl Rogers went on a long journey to Japan where he was warmly received and able to establish highly enriching personal and professional relationships. In that same year, he published the book *On Becoming a Person* which quickly became a bestseller.

In that book, he explored the application of client-centred principles to other areas of human life: education, interpersonal relationships, family relationships, intergroup communication and creativity. He presented his approach as a philosophy of life, a way of being or, as translated by one Brazilian editor, the "knack of being". Almost one million copies of the book have been sold.

The deteriorating work climate in Wisconsin might explain why, in January of 1964, and after spending one year – between 1962 and 1963 – as a guest at Stanford's Center for Advanced Studies in Behavioral Sciences, he left the University of Wisconsin and went to the Western Behavioral Sciences Institute which had been set up at Stanford by one of his former students from Wisconsin, Richard Farson, and the physicist Paul Lloyd.

Rogers then began to spend more and more of his time working with encounter groups. His interest in groups first surfaced in 1946/1947, around the same time as Kurt Lewin who was at the National Training Laboratories, in Bethel.

Lewin (1948) and his team seemed to be more interested in training business executives and professionals, and the personal development of participants was considered to be accessory. Rogers, on the contrary, considered this latter aspect to be a fundamental priority, and, especially from 1960 onwards, after forming the Center for Studies of the Person in La Jolla (1968), he regarded encounter groups as the tool of choice not only for personal development but also for education, leadership, management and the resolution of conflict.

The book published in 1970, *On Encounter Groups*, was seen as a handbook, appreciated by lay people and professionals alike, and quickly became a mandatory reference guide for specialists working in the area of group intervention. In 1968, the film *Journey into Self*, produced by Bill McGaw, won the Academy Award for Best

Documentary Feature of the year. The film portrayed a group therapy session facilitated by Carl Rogers, a concrete example of the theory and practice that would come to be described in *On Encounter Groups*.

In 1971, together with his son, David, and Orienne Strode he developed the Human Dimension Project, proposing encounter groups within medical education and for doctor-patient relationship training.

At that time, his attention was also highly focused on the field of education for which he proposed student-centred learning, that is, experiential learning. This learning seems to have much in common with what Paulo Freire (1968/1974) referred to as "non-banking education", though, at the time, Rogers was unaware of Freire's work. Experiential learning generated a large body of research which is partly described in two books that summarise Rogers' thoughts on learning: *Freedom to Learn*, published in 1969, and *Freedom to Learn for the 80s*, published in 1983. In the latter, Rogers provided a summary of the big educational projects conducted in Louisville, the so-called Louisville project, and in the group of catholic schools of the Immaculate Heart. The essence of his message was that students tend to learn better, tend to be more assiduous, creative and better able to solve problems, whenever teachers foster the humane and facilitative climate he was proposing.

At the age of 70, Carl Rogers was the first American psychologist to receive the American Psychological Association's two highest awards, for both his scientific and his professional contributions.

From 1972 onwards, he dedicated himself more intensely to intervention work and the appraisal of social and political factors, exploring the possibilities of growth and creativity that could be found in encounter groups. He engaged in the Irish conflict by facilitating a meeting between Catholics and Protestants, a meeting which was filmed by the producer of *Journey into Self*. Similarly, he facilitated interracial meetings in South Africa, in Brazil during the military dictatorship, and in "Gorbachev's" Russia.

Carl Rogers shares the essence of his ideas on social and political intervention in his book *On Personal Power* which was published in 1977. In this book, he presents his Person-Centred Approach model and philosophy of intervention not only as a model of psychotherapy but as an effective approach for all human relationships, whether they be helping, personal or political relationships. Farson stated that Rogers was "a man whose cumulative effect on society made him one of the most important social revolutionaries of our time" (1974, cited by Rogers, 1986a, p. 14).

In terms of encounter group dynamics, Rogers analysed the underlying success of the 1978 Camp David negotiations, between the Israelis and the Egyptians, and proposed that this model be used to resolve social and political conflicts. It is worth mentioning that the "Camp David model" was once again used, with relative success, in 1995 to end the armed conflict in Bosnia, hopefully for good. In 1985, Rogers facilitated a workshop in Rust, Austria, bringing together 50 international leaders, including the former president of Costa Rica and

high-ranking politicians and diplomats, whose aim was to work on the Central American crisis using the encounter group model. Rogers spent the final years of his life doing research and engaging in large-scale cross-cultural workshops or peace efforts. Finally, in 1987, he was on the list of nominees for the Nobel Peace Prize. Unfortunately, he died before the Nobel Committee made its announcement, at a time when, despite his age, he was still perfectly lucid, extremely active and enjoying life to the full, as he used to say to his closest friends: better than ever.

These final years, especially after the death of his wife, Helen, in March of 1979, were also marked by a stronger interest in Human spirituality, in the transcendence of one's self to become part of the greater whole and harmony of the Universe. He became aware of the importance of "presence" in therapy, which he associated with a form of transpersonal communication in which intuition plays an important role. He presented this as a new avenue to explore within the scope of his approach and in the domain of, what could perhaps be called, altered states of consciousness.

Thus, in a certain way, things came full circle. Having started with an interest in, and commitment to, theology and a pastoral career, Carl Rogers came to the end of his life with a renewed interest in the spiritual realm of Human Beings, but in a spirit of freedom and tolerance, far removed from the fundamentalist, narrow-minded view of his youth. He will, perhaps, have held on to his unwavering faith in a better future, without ignoring, as he so often emphasised, the

misery, pain, suffering and evil that accompany us on our journey through life.

Client-Centred Therapy and the Person-Centred Approach

Initially, Carl Rogers focused his efforts on the search for an effective therapeutic tool, an endeavour he carried out in a systematic and pragmatic fashion. Having questioned the dominant models of the time — psychometric, psychoanalytic and behavioural — he proposed shifting from a directive to a non-directive attitude in therapy and counselling, a proposal purely based on empirical experience. This all stemmed from his trust in the ability of individuals to discover within themselves the solutions to their own problems, solutions which he believed to be the most appropriate.

This initial phase led him to structure what was then known as the "non-directive approach in therapy", an approach that was substantiated by an important body of ground-breaking research. Major works on the dynamics and the process of therapy date back to this time.

He developed the technique known as *reflection*, a term borrowed from the social worker, Elizabeth Davis, according to Rogers and Haigh (1983). Raskin (1978) wrote that one of Rogers' greatest contributions to the development of therapy was to clarify a technique

which enabled therapists to express respect towards their clients, something that many therapists talked about but did not practise.

The underlying assumption of non-directive therapy was that each person has within him- or herself the ability to uncover the solution to his or her own problems and a tendency towards "growth", in other words, a tendency to develop more mature behaviour.

Empathic understanding thus became the most effective technique for the facilitation of awareness, considered by Axline (1947) to be a prerequisite for successful therapy. Confidence in awareness echoed the dominant theories of the time. Later, partly thanks to the work developed by Gendlin (1986), awareness became less important than *experiencing*; for this disciple of Rogers, who took an extreme view, awareness was an accessory. Experiencing would be the process by which "the person becomes aware of the incongruence between the self and the organismic experience and the means by which to overcome that discrepancy" (Wood, 1994, p. 218).

In a second phase, Rogers decided to effect a change, to shift his focus from techniques to attitudes and the relationship. The Client-Centred Therapy model thus rested on three pillars: the actualising tendency; the six necessary and sufficient conditions for therapeutic change; and the non-directive approach.

The actualising tendency

Carl Rogers postulated that:

> There is a formative directional tendency in the universe, which can be traced and observed in stellar space, in crystals, in micro-organisms, in organic life, in human beings. In humankind it extends from a single cell origin to complex organic functioning, to an awareness and sensing below the level of consciousness, to a conscious awareness of the organism and the external world, to a transcendent awareness of the unity of the cosmic system including people (Rogers, 1959, pp. 184-185).

He went on to specify that: "This tendency is called the actualising tendency when applied to human development. It is the ever-operating tendency of an organism to develop all of its capacities in ways which serve to maintain or enhance the organism" (1959, pp. 255-256). For Rogers, the actualising tendency was a special kind of formative tendency, suggesting that the potential for change was ingrained in human nature.

The six necessary and sufficient conditions for therapeutic change

In 1957, and on the basis of his research results, Carl Rogers published an article in which he postulated the six necessary and sufficient conditions for therapeutic change to occur: two persons are in psychological contact, the first, whom we shall call the client, is in a state of incongruence, being vulnerable or anxious; the second, whom we shall call the therapist, is congruent or integrated in the relationship; the therapist experiences unconditional positive regard for the client; the therapist experiences an empathic understanding of the client's internal frame of reference and communicates this experience to the client; the communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

From his perspective, if these six conditions are present, then constructive change will occur in the client; if one or more of these conditions is absent, then change will not occur; if all six conditions exist, then the greater the degree to which conditions two to six are present, the more marked the change.

The non-directive approach

In Rogers' view, a non-directive attitude is the expression of a philosophical stance based on trust in the client and in his or her capacity for self-organisation and self-determination. It is the certainty that the client has the best and most creative solution to his or her problem, through which the client is able to self-actualise, provided the necessary conditions are present. The non-directive approach "aims directly toward the greater independence and integration of the individual" (Rogers, 1942, p. 28).

In a third phase, the emphasis shifted to the relationship and Rogers explored the potential of his approach beyond the field of therapy, extracting its inherent philosophy and modulating variants for application in the various domains of Human life. It was at this time that the Person-Centred Approach emerged, an expression of the philosophy underlying Client-Centred Therapy, an approach which could be used in any type of relationship.

The Person-Centred Approach would be characterised by trust in the formative tendency and in its corollary, the actualising tendency, which under adequate circumstances (also known as the core attitudes) enable biological or social organisms to self-actualise.

Having referred to the formative tendency (we prefer to call: tendency towards complexification), which Rogers equates with negentropy, and to the actualising tendency (we prefer to call: tendency towards hyper-complexification), we feel it is important to

also take a detailed look at the core attitudes, as they represent the highest common denominator among the different interpretations of Rogers' approach.

These attitudes were initially theorised by Carl Rogers within the framework of his hypothesis on the six necessary and sufficient conditions for therapeutic change: congruence, unconditional positive regard, empathic understanding and, at a later stage, as already mentioned, presence.

These essential and inseparable attitudes are inherent to both therapeutic relationships and experiential learning relationships and can be generalised to all social interactions.

For Rogers, congruence means behaving in a way that is consistent with one's actual experience, the totality of one's experience, the awareness of and ability to communicate one's experience; it is being coherent with oneself in the space-time of the social interaction, in the here and now of the relationship. For Campiche, Hippolyte and Hipólito (1991), freedom, authenticity and creativity are essential conditions, but insufficient for freedom and creativity to emerge.

According to these authors, unconditional positive regard means accepting the Other and his or her discourse without judgement, promoting a sense of freedom within the Other, enabling the Other to create and direct his or her own experience towards the resolution, or not, of his or her own problems. Empathic understanding means understanding the Other's world as he or she

understands it, to see it as he or she sees it, that is, as if we were looking at the Other's world through the Other's eyes, through a common language. Empathic understanding also means adequately communicating to the Other our perception of his or her world and "way-of-being-in-the-world", constantly adjusting the accuracy of our understanding through intervention, working with the Other to understand the possible meanings of his or her experience and accompanying the Other as he or she restructures his or her system of references. Maintaining this attitude implies the integration of two separate, consecutive phases. In a first phase, we see and perceive the world of the Other as he or she sees it from his or her internal frame of reference, as if we were the Other, but without losing sight of the difference between us that enables our relationship. In a second phase, our perception is confronted with the Other's reality and, through dialogue, we constantly adjust the accuracy of our understanding. This, inevitably, means that we must have an understanding of the culture in which the person has developed, and the world surrounding him or her has developed, that is, the institutions that govern the person, the situation in terms of labour relations. In short, we need to know as much as possible about the dimensions and frames of reference inherent to the Other's world.

Regarding *presence*, Rogers did not have time to fully develop this concept. He referred to it when he stated that:

> When I am at my best, as group facilitator or therapist, I discover another characteristic. I realise that when I am closer to my inner, intuitive self, when I am somehow in touch with the unknown in me, when I am in a slightly altered state of consciousness in the relationship, then whatever I do seems to be full of healing. Then simply my presence is releasing and helpful. There is nothing I can do to force this experience, but when I am able to relax and come closer to the transcendental core of me, then perhaps I behave in a strange and impulsive way in the relationship, in a way that I cannot justify rationally and that has nothing to do with my thought processes. But those strange behaviours turn out to be right, in some way. At those moments it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself, and has become part of something larger. Deep energies of healing and growth are then present (Rogers, 1987a, p. 70).

Towards the end of his life, and without ever abandoning preceding perspectives, Carl Rogers would nevertheless come to recognise that the moment of fundamental change in therapy was linked to something he called "moments of movement", strongly associated with the notion of presence.

The Dissemination of Rogers' Thinking in the Human Sciences

Carl Rogers' ideas became widespread in the "fields" of psychology and psychotherapy, but his influence extended well beyond these fields, reaching all corners of the human sciences.

When he started working as a therapist, psychotherapy, in the United States, was considered to be a medical activity, exclusively within the remit of medical practitioners. Not only did Rogers object to this monopoly, he argued that medical practitioners, whose training focused mainly on diagnosis and directing others, did not have the proper training to practice this new profession, a profession which he naturally considered more suited to those with a background in psychology.

He initially used the term "counselling", a strategic measure mainly to avoid being accused of practicing medicine illegally. The practice of psychotherapy by psychologists in the United States was, to a certain extent, influenced by Rogers' work and the generalisation of his outlook.

His influence has become so ingrained in society that few people nowadays will be aware of the fact that current research methods in psychotherapy are indebted to Rogers' pioneering work and commitment to using concrete data, by fully recording interviews and treatment programmes using the limited resources that were available at the time, such as 78 rpm phonograph records that could

store up to about three minutes of audio data, transcribing and analysing transcripts, applying a wide range of psychometric tests and by developing countless tools designed to assess the therapeutic process.

Most of his concepts were integrated by the many schools of therapy; they even entered day-to-day language. The notion of empathy was embraced by all schools, and there is no one who is unaware of the importance of this concept, from psychoanalysis, particularly through Kohut (1977), to the cognitive-behavioural theories.

Likewise, the notions of congruence and client acceptance became so widespread that Rogers' therapeutic approach, diluted and integrated by the many schools, seemed doomed to disappear. Non-directiveness has perhaps been the most difficult concept to grasp and integrate, despite the fact that many schools consider their therapeutic approach to be non-directive.

Rogers' principles have infiltrated the world of education, medical and legal practices, industry, pastoral counselling and community work. They have influenced marriage, partnerships, family life and racial and geopolitical issues. They have helped to empower people from all walks of life and in a variety of occupations (Rogers, 1986a).

Some of Rogers' followers paved new paths, becoming "leaders of schools", the description of which is beyond the scope of this book. Examples are: Gendlin (1978) and experiential therapy,

characterised by his technique known as focusing where special emphasis is placed on experiencing; Rice (Wexler & Rice, 1974) and emotion-focused learning; and Gordon (1995), who applied Rogers' principles to training and personal development programmes for professionals and non-professionals alike (teachers, managers, leaders, salesmen, doctors and parents, among others).

The Rogerian approach also had a profound effect on the field of social intervention, through the dissemination of the case work model, the so-called non-directive interview and career guidance.

One might think that the cycle was complete, and that by becoming part of the culture Carl Rogers' thinking would cease to be relevant and unique, becoming a blur in the cultural heritage shared by all and reclaimed by none.

Carl Rogers in Contemporary Psychology

During most of his life, Rogers was against the institutionalisation of his thinking or ideas. This was made clear in a letter he wrote, in early 1970, to Professor Caldeira in Lisbon, who was in the process of organising a psychotherapy training programme, based on what he considered Rogerian principles, and forming a scientific society that was to adopt a Rogerian perspective. In his letter, Rogers told Caldeira that he would not endorse the use of his name for such a programme or society, that he was opposed to the institutionalisation of his ideas, as this was incompatible with his own personal philosophy.

Towards the end of his life, he saw that he had no control over this process, as scientific societies were being formed almost everywhere without his endorsement. Thus, he eventually came to associate himself with the founding of the European Association of Client-Centred Therapy and Person-Centred Approach. He also endorsed the launch of the Association for the Development of the Person Centered Approach, a North American society, but with many international members, that operates in an extremely unstructured fashion, yet fully in line with Rogers' philosophy.

Gradually, psychotherapy training programmes also began to appear, promoted either by the Center of Studies of the Person, founded by Rogers in La Jolla, San Diego, or by institutions he

recognised or by various scientific societies the world over belonging to the Rogerian movement.

His departure from academia, upon leaving the University of Wisconsin to go to California, led to a certain decline in the direct influence of his ideas in the field of psychotherapy training.

Over the years, new societies have been established around the globe. Although the Rogerian movement does not have a formal international structure, a regular meeting is held every three years on the occasion of the International Conference for Person-Centered and Experiential Psychotherapy and Counselling, where the focus is primarily on psychotherapy. Also, held every two years is the more comprehensive and experientially-oriented International Forum of the Person Centered Approach, bringing together representatives from the diverse fields in which the Person-Centred Approach has been applied. Carl Rogers was present at the first meeting which was held in Mexico.

The Rogerian movement has, gradually, become aware of the wealth of Rogers' legacy and of the fact that even today, given the range of existing psychotherapies, Client-Centred Therapy continues to be among those most firmly anchored in research and solidly rooted in philosophy.

A second wave of therapists surfaced within the "Rogerian world", sometimes considered purists or orthodox who, without questioning the philosophy behind the Person-Centred Approach or its applicability to numerous areas of Human life, advocate a return, in

terms of the psychotherapeutic setting, to the so-called Client-Centred Therapy model which rests on the three pillars we have already discussed.

Also, in the last decade, we have witnessed a return of the Rogerian approach to academia and a resurgence in research which, to a certain extent, had remained in the background for a number of years while the focus was on exploring the applications and limitations of the philosophical model.

What impact might Carl Rogers have today? We conducted a short survey with a small sample of Rogerian therapists from various places around the world, some of whom are well known, either because they were disciples of Rogers and worked directly with him or because they have made a significant contribution to the development of the Rogerian model and its practice.

Barrett-Lennard (1995, personal communication), an honorary fellow of Murdoch University, Australia, renowned for the important work he has conducted in the field of psychotherapy research, and one of Rogers' collaborators during the Chicago period, provided us with the following personal statement:

> For us, the impact of Rogers is alive and immediate and at the same time profound. For others, his influence is historical. What I mean is that he helped psychology to become what it is today, a domain of interest, research, knowledge and cultural influence. As a force contributing to the development

of psychology, his influence is difficult to disentangle and separate from other historical influences. Professionals in Clinical Psychology and Psychotherapy (for example) tend to be relatively unaware of what are now only regarded as indirect influences.

Carl's impact is thus direct and indirect, in the context of the helping professions as well as culture in general. And one of the things I find most interesting is the way in which it has continued to spread across diverse fields and different regions of the globe, at different times. The profound effect on clinical psychology dates back to the forties and fifties, spreading in the field of disciplines tied to counselling and psychotherapy. Research shows that in the field of the nursing sciences, for example, the impact only became substantial in the seventies and eighties.

Regarding differences in penetration by region, we found that there was virtually no awareness of Carl's work in England before the mid-sixties, and it only gained a strong presence there in the seventies. Progress on the European continent is well known, but it is only now that he is gaining recognition in Eastern European countries. In Central and South America, Carl's work did not gain visibility until the late seventies and eighties. I have had some correspondence with colleagues from Middle Eastern countries, but what about Central African

countries? When will Carl's work reach the most populous countries such as China and India?

Marge Witty (1995, personal communication), a North American psychologist stated that:

> Rogers' work provided us with a radical view of human nature and life. Rogers viewed humans as fallible beings, vulnerable to myriad forms of influence, completely unique, but who, as with all creatures, aspire to actualise their genetic design.
> Under favourable circumstances, people seem to move towards a fuller life and perfection of their capacities. None of this is the work of a God or alien force. Their nature being neither good nor bad, fully capable of both, good and bad, they are as innocent as a snail or a panther. We can guide ourselves, we can honour ourselves and our lives without authoritarian leaders or gurus of any kind. Rogers' thinking was the first to rid us of Satan.

Kathy Moon (1995, personal communication), a Chicago-based psychotherapist, also wrote down her opinion:

> I think that, in a way, Rogers had more impact on educational than on psychological thinking, without insinuating that this was translated into educational practice. Perhaps I am in a bad

> mood today, but I think that there are a number of "eclectic" therapists in psychology who believe that *being client-centred* is among their list of values, without however having a deep or theoretical understanding of what that means. What I am trying to say is that they think they are talking about everything their clients wish to talk about, but in reality they are routinely directive, manipulative, authoritative, diagnostic, despite believing they have been strongly influenced by Rogers and that they are basically client-centred therapists.

Another American therapist, Gary Prouty (1995, personal communication), renowned for his ground-breaking work with severely disturbed clients, stated:

> For me, the impact of Carl Rogers' psychology is in the way it asserts the existential value of each individual. This is painfully necessary given the continuous increase in institutional power in modern life. Among contemporary theories of human nature, Rogers' is the most expressive in terms of ethical care, which seems to be disappearing. Current sociological and economic outlooks are quite 'anti-person'.
>
> Carl was a pioneer in the development of a quantitative approach in psychotherapy. He was a pioneer in the non-pathological view of homosexuality. He was a pioneer in the legal battle enabling psychologists to practice psychotherapy.

> He was also a pioneer in the use of a recording technique in psychotherapy.

Márcia Tassinari (1995, personal communication), a Brazilian psychologist and therapist, and professor at Saint Ursula's University in Rio de Janeiro, said:

> Rogers is viewed as much a psychologist as an educator and psychotherapist. The impact in Brazil is substantially lower than that of other theoretical orientations (such as psychoanalysis, body therapies, psychodrama). There are few formal groups (in terms of associations or a society), but there are many professionals, and informal groups of professionals, who use the theoretical framework of his approach in several fields, mainly in psychotherapy.

William Barnard (1995, personal communication), a Canadian therapist who first met Rogers in 1960 through encounter groups for employee development at the Canadian Christian Youth Association, had the following to say about Rogers:

> I corresponded with Carl and received many of his articles in unpublished format, which I used in my work as a consultant for a large Canadian company, the Steel Company of Canada, and the holding company of a large Canadian multinational,

John Labatt. Later, I taught at a University of Toronto school of higher education, specifically adult education, counselling and consultancy skills.

My conviction is that Carl's genius was shown by his ability to learn from experience, to bravely speak out about this learning in contexts in which it was neither understood nor appreciated, and by the combination of his self-discipline and creativity that gave rise to new insights, not only in psychotherapy but also in the different fields of human behaviour and relationships.

His style was to let his ideas circulate freely, sharing them without staking a claim to them, avoiding their becoming dogmatic and associated exclusively with him. By floating these ideas freely, they invaded all domains of human life, and many who use these ideas have probably never heard of him, not only in psychology but in almost all other professions.

He also learned from and influenced others. The most important lesson I learned from Carl was to avoid becoming a Rogerian therapist or taking on the set of beliefs that he himself had come to accept over the course of his life, but to become more fully myself, to make responsible choices and to talk with others.

For Kazuo Yamashita (1995, personal communication), a Japanese psychologist and psychotherapist, the Person-Centred Approach:

> Brought a democratic way of being to the person-to-person relationship, a self-direction by which each person values the other; it introduced the importance of being authentic in the encounter and, as is well known, a feeling similar to that of Eastern culture.

Charles Stuart (1995, personal communication), a North American psychologist and psychotherapist, stated:

> An important learning Carl helped me to make was: when I listen and imagine what it might be like to experience what the other person is experiencing, I feel a connection that up until now has been completely alien to me ... an intimate connection that forms without any manipulation on my part. And if someone had told me about this experience before it became a part of me, I would not have known what it meant.
>
> The second important thing I learned through the Person-Centered Approach was: when I take the risk of sharing my immediate experiences, not only do I find that the other person reciprocates but I also feel a deep inner understanding,

> a kind of bond that feels wonderful and fills me with the sense of a life worth living to the full.
>
> And the third thing I learned was that being my true self in the relationship can be risky, and sometimes trigger hostility, negative evaluation, and thorniness. But these occasions are surprisingly rare. More often than not, what happens is what I described above. Thank you for giving me this opportunity to think about what he means to me and to so many others in this network.

Nathaniel Raskin (1995, personal communication) was one of Carl Rogers' students at Ohio University, and a collaborator of Rogers during the Chicago period. He is currently an honorary fellow of Chicago's Northwestern University and is world renowned for his scientific work. Raskin wrote:

> During Carl Rogers' professional life, psychologists and psychiatrists were viewed primarily as specialists with the ability to diagnose problems in normal people and guide them towards solutions. Given the contraction in medical and social services, in recent decades, pressure to follow this model has mounted.
>
> Not only did Rogers declare his belief that individuals, clients, have the ability to gain a sense of self-understanding and devise their own solutions, but he also developed the theoretical and scientific foundations for this approach and

> expanded it to include group therapy, classroom students, communities of strangers, and groups in conflict with each other.
>
> He left behind many examples of his work, and the way in which he lived served as a personal example of his own philosophy.

Alberto Sagrera (1995, personal communication), a Mexican university professor who organised the 1st International Forum of the Person Centered Approach, stated:

> Carl Rogers was the person who had the most impact on my personal and scientific thinking in terms of interpersonal relationships and the facilitation of human development at the individual, educational, organisational and social levels. However, the implications of his ideas have yet to be fully understood and developed on each of these levels.
>
> In Mexico, there are postgraduate courses on the Person-Centered Approach and his influence has extended to other undergraduate and postgraduate programmes.
>
> The future of Psychology and all other helping professions will certainly be enhanced by contributions from academics and practitioners who subscribe to this approach.

Anne-Marie Blanc (1995, personal communication), a French psychologist and psychotherapist, said:

> Well, I feel appreciated and accepted exactly as I am and I also accept myself exactly as I am (...). This feeling, frequently expressed by people during the course of their Rogerian-based psychotherapy, sums up, I think, the essence of what Carl Rogers' process and approach have brought to psychotherapy and the helping relationship in general: acknowledging the client as a person, recognising the person on the basis of his or her subjective frame of reference, respecting the person's dignity and capacity for growth.
>
> This valuing of the subjective experience is, as expressed by Max Pagès, "a rejection of the reification and objectification to which the client is normally subjected to by the therapist (...), no longer is the client observed and analysed as if he or she were in a glass cage, in short, treated as a thing and manipulated". The "psychological object" once again becomes the "subject" of his or her own process of growth.

And, finally, Ana Sofia Josué (1995, personal communication), a final-year psychology student at a faculty in Lisbon at the time of the survey, who expressed the impact Rogers was having on her training as follows:

> Discovering Rogers compelled to explore the effect of his approach on me personally, and in this sense he has influenced some of the directions I have taken as a person. His greatest influence on me has expressed itself through the progressive change in the way I look at the (my) world. I feel more open to life, to others, to myself. I have become slightly more adept at letting myself be as I am and 'letting' others be as they are. In fact, what I feel has been happening is the gradual discovery of a "looking-seeing", "hearing-listening", "speaking-saying", of an attentiveness from the inside looking out and from the outside looking in, a learning to experience the moment.

In these times of economic, social and humanitarian crises where individual values tend to disappear, not for the purpose of a more appropriate social outlook but for an outlook driven by macroeconomics, one in which individuals are valued solely on the basis of their economic worth and where life ceases to have unique value (look at the cuts in health and social care expenditures being made in all developed countries), which to us reinforces Rogers' message of needing to return to the individual, to the person, not the "personal" or "individual" incompatible with social being but to the individual person who gives meaning to social life, the organism in the isomorphic sense, at all levels of its organisation, from a deeply ecologic, holistic and humanistic stance. Carl Rogers was one of the leading figures of the so-called "third force" in psychology, Humanistic

Psychology, a humanistic alternative to the essentialist and deterministic ideas held by psychoanalysts and behaviourists.

Chapter III

The Role of Empathic Understanding

Empathic understanding is the favoured form of intervention in the Rogerian context and it is one of the most important features of Client-Centred Therapy. As the most visible aspect of the "iceberg", it has been the target of sarcasm and mockery. But, from a certain time onwards, its role became so overrated that it could not be dissociated from its historical background, nor could it be forgotten that "Non-Directive Therapy", the name initially attributed to Carl Rogers' therapeutic approach, was closely tied to the public's perception of his "reflecting" technique.

In a way, what was being inferred from the term non-directive was not what Rogers would have liked it to be, which was to allow the client to lead the therapeutic process; what was being inferred was a sense of repetition, of psittacism, something which greatly tarnished the notion of empathic understanding and the impression other theorists had of the Person-Centred Approach or Non-directive Therapy.

This was probably one of the reasons why Rogers decided to replace the term "Non-directive Therapy" with one he regarded more appropriate: Client-Centred Therapy. By looking at how Rogers'

thinking developed, we can get a better understanding of the various interpretations of the empathic response mode that emerged within the Rogerian movement.

According to Peretti (1997), Rogers'[1] early training was influenced by, as he himself came to acknowledge, the dissident psychoanalyst, Otto Rank, who left him with a vivid memory of the aspects relating to the quality of the therapist-client relationship, something which probably overshadowed the importance of Rank's theoretical and formal contributions.

In the earliest stages of his training, Rogers will also, inevitably, have been influenced by the impact of the "orthodox" psychoanalytic movement on American psychology and psychotherapy and, as such, it seemed clear that within the psychotherapeutic process (we will see that empathic understanding is intimately linked to the therapeutic process) client awareness would be the essential and structuring element for psychological change.

Rogers wrote with outstanding quality and great human warmth, his texts steeped in personal testimonials and confessions, but rarely did he seem concerned with presenting his own concepts and theories in a systematic manner. One of the first works attempting to synthesise Rogerian thinking and conceptualisation was the book

[1] Regarding the influence of Otto Rank's thinking and practice, the reader is referred to Rogers' personal account in *Carl Rogers The Quiet Revolutionary* (2002, Roseville: Penmarin Books, pp. 112-113, 239).

published in collaboration with Kinget, *Psychothérapie et Relations Humaines* (Rogers & Kinget, 1971a, 1971b). The influence of the psychoanalytic ideas of the time is obvious in the book, given the emphasis placed on certain themes pertaining to the psychoanalytic model such as, for example, the problem of transference and transference-based relationships; nevertheless, the book continues to be very useful and timely. Awareness of self was a fundamental and explicit concern for both Rogers (1987) and his closest collaborators such as Axline (1947), who considered it a prerequisite for successful therapy.

Empathic understanding was proposed as the means *par excellence* to help clients gain spontaneous insight into their lived experience, enabling clients to readjust their perception, integrate their experience and expand their experiential field. In *Counseling and Psychotherapy* (1942), a book written exclusively by Carl Rogers, we once again come across this notion of insight, described by Rogers in the following way: "It involves the reorganization of the perceptual field. It consists in seeing new relationships. It is the integration of accumulated experience. It signifies a reorientation of the self (...) There appear to be several types of perception which we group together as insight" (pp. 206-207).

On the basis of a cross-cultural reading, it seems to us that moments of insight were interpreted as the foundation for change. In this sense, empathic understanding had a *raison d'être*, a meaning and an intention that we will come back to at a later stage.

We feel it is important to take a brief look at the development of what is considered to be structural and mutative in therapy, in other words, the *moment of change* in psychotherapy.

Rogers' thinking underwent a fundamental shift while he was at the University of Wisconsin, where he had the opportunity to work with schizophrenic patients at the Department of Psychiatry, doing important research on the impact of the therapeutic relationship within psychiatry, the details of which can be found in *The Therapeutic Relationship and its Impact* (Rogers, Gendlin, Kiesler, & Truax, 1967).

In one of the chapters of that multi-authored book, Gendlin (1962, cited by Gendlin & Rogers, 1967) develops another way of looking at the process of change in therapy, a way that mainly involves the notions of experience and *experiencing* which, in a way, he believed took precedence over insight. Thus, gradually moving away from Rogers, Gendlin went on to develop experiencing as the fundamental driver of the therapeutic process, stressing the importance of experiencing *in the company of*, *in relation with*. He introduced the idea of the importance of *presence*, a concept which Rogers came to integrate as the fourth core condition to facilitate therapeutic change. *Presence* is "being with" and *experiencing* is the experience of that "being with". Experiencing and "becoming aware" were regarded as inseparable aspects of the therapeutic process (Gendlin & Rogers, 1967). In our view, however, Gendlin's thinking evolved towards a clear, exclusive even, preference for experiencing.

Thus, regarding therapeutic process theory, there was a shift in terms of what was valued and given exclusive emphasis, a shift from insight, pertaining to the cognitive domain, to experiencing, associated with the realm of feelings and emotions.

It is interesting to see that, given these different ways of being, interventions and empathic understanding, as an instrument of intervention, would evolve and consequently so too would their conceptualisations.

The progressive change in Gendlin's (1978) thinking led to the formation of a "school" called Experiential Psychotherapy where emphasis is placed on the technique of focusing. Experiential Psychotherapy gradually became independent, a movement in its own right, though it remained on the fringes of the Rogerian movement to which Gendlin, in 1990, claimed to continue to belong.

This technique can be taught to the client, the intention being to help the client to experience, preferably, the felt feeling, the felt sense, something that manifests itself as a concrete perception "in one's stomach (like 'butterflies in your stomach'), or wherever a given individual feels fear, hunger or joyful excitement" (Gendlin & Tomlinson, 1967, p. 114).

In this process of theoretical advancement, perspectives arose that viewed empathic understanding not in terms of achieving a greater sense of "awareness", rather as a means to increase presence or the intensity of experiencing.

In *Psychotherapie et Relations Humaines*, Rogers and Kinget (1971b) claimed that: "(...) given that the Rogerian therapist does not seek to judge, question or reassure, nor explore or interpret, on the contrary, he tries to *participate in the client's immediate experience*, it naturally follows that his response must be in line with the client's thinking, to the extent that he takes what is said and returns it in a way that he, at the very least, recognises as his own" (p. 57).

In line with Rogers' (1999) thinking, we propose the exclusive use of the expression: empathic response. The value of this type of response mode resides in its ability to meet one of the necessary and sufficient conditions in therapy, namely that the client minimally perceives the therapist's attitudes of congruence, unconditional positive regard and empathic understanding.

Contrary to Rogers' view, Gendlin (1990) believed that the fact that the client perceives these attitudes on the part of the therapist was neither a necessary nor a sufficient condition. It could be useful, but no more than that, and he emphasised that "client-centered reflecting is a necessary baseline for using other things." Thus, the "client-centered reflecting-method is the central thing *with which* to use everything else" (p. 207).

For Rogers and Kinget (1971b), empathic responding, as "insignificant and repetitive as it may seem, is nevertheless incredibly effective" and it is the means *par excellence* for facilitating *spontaneous* [author's italics] awareness of the lived experience" (p. 58). Regarding awareness, the authors defended that dialogue should

enable the client to feel understood and the therapist recognised for his or her expertise.

During this "non-directive period", empathic responding was the main tool available to the therapist. Rogers & Kinget (1971b) considered three different types of reformulation:

1 — Reiteration. When we watch the recordings of Rogers at work (throughout his professional life), we can see that, on average, he merely repeats what the client is saying, sometimes using a slightly interrogative tone, but not in a parrot-like manner, because the intonation and value he places on what he says truly resonates with the client. Rogers and Kinget state that reiterative or repetitive empathic response is the key feature of Rogers' intervention. More "experienced" therapists frequently use this type of intervention, because they are more at ease, feel more sure of themselves;

2 — *Reflection of the feeling*. The therapist takes up what the client has said and responds empathically, above all, to the implied feeling, causing an "illumination of the background that enriches the figure". In Rogers' and Kinget's view, this is similar to the Psychology of Form or Gestalt approach. This type of empathic response focuses more on the lived or implied feeling than on the factual elements of the dialogue;

3 — *Elucidation or clarification.* In this type of intervention, the therapist extracts a certain number of aspects that are implied

> but have not been clarified in the client's discourse. It is a deductive exercise that, in a way, approximates interpretation, less aseptic compared with other forms of empathic understanding. From an intellectual point of view, it is apparently the most satisfactory option for therapists, especially for beginners, because being able to "grasp" what has been implied is far more rewarding than accompanying the client step by step in a more or less repetitive manner.

In our view, Rogers favoured the straightforward reiterative empathic response, and Kinget felt that elucidation or clarification bordered on explicitness, a type of intervention that very rarely appears in Rogerian discourse.

Caldeira, who had a major impact in terms of training Rogerian therapists in Portugal, directly and indirectly through his followers, developed a detailed conceptualization of the cognitive or intellectual aspect of the empathic response, which he called reformulation.

In their article on psychotherapy in schizophrenia, Dias and Caldeira (1982) provided quite a detailed taxonomy of reformulations, thirteen different types given through examples, which we transcribe below. These examples were extracted from interviews with patients diagnosed with schizophrenia, interviews which were carried out by three different psychiatrists at different times.

"Type 1 - Reflection (corresponds to Rogers & Kinget's, 1971b, notion of reiteration):

C - It seems that I can only think about bad things, it feels like I'm going to die; I can't poop, I'm dying.

T - So it seems that you can only think about bad things...you associate not being able to poop with abortion and death.

Type 2 - Clarification (approximates Rogers & Kinget's, 1971b, idea of elucidation or clarification):

C - (...) Then everything gets jumbled up, Joaquina rang asking me to come over to her house, but I couldn't because Dr. G. was here. Then I'm alone at home with my aunt, it bothers me that she's on her own at home. So I didn't go out. I had no need to go out anyway.

T - And does it bother your aunt?

C - No, it doesn't bother my aunt, it bothers me though.

T - So, you worry?

C - Yes, I worry about my problems and those of others, it's stupid.

T - Despite thinking it's stupid, you can't live your life, you can't behave in the way you think is best.

Type 3 - Figure-ground reversal (In their gestalt-related analysis, Rogers and Kinget found that reformulation of the feeling enabled the figure to be highlighted to the detriment of the background):

C - You see what happens to me?... it could only happen to me. It seems that everything is going well, we love each other (crying) and then, bam!

T - You believe you're the only one to be unlucky in love?

Type 4 - Synthesis and reformulation of feelings:

C - I haven´t been able to poop for a number of days and I'm afraid that it will be just like the second time I was sick, because I've got it into my head that the effort needed to poop is the same as having a child, a child I never had because I had an abortion twice or more. The first time it was horrible, because I was going out with a boy that was schizophrenic, schizoid, I don't know much about that, I was 18 when I did it and it was horrible. If it hadn't been for a cousin, Antonieta, a distant cousin from my father's side of the family. The abortion was horrible, because I was very young and that boy would turn to me and say, so you're having an abortion, can't you see that a little blue-eyed boy is going to come out? Instead of helping me; because my father said that he didn't want any unmarried mothers in the house. It was horrible, I was 18 years old, "you are sixteen, you are beautiful and you are mine", he would sing. All he did was to go on telling me these things instead of helping me (stops and stays silent). Where was I?

T - You felt very lonely when you had the abortion.

Type 5 - Reformulation and elucidation of what is implied (a "fine-tuned" elucidation):

C - (Crying, thinking about a relationship that ended months ago)

I gave it my all...working and studying... I had to get up at six in the morning to catch the train, I'd have lunch at my parents' house...at night he would study at home with a friend... I don't really know what we ate... Oh yes, I'd bring home food from my parents... all that sacrifice for nothing... It's all over... I gave it my all.

T - You're suffering because you feel it's so unfair that you sacrificed so much and never received the right response.

Type 6 - Empathic, kinetic reformulation (digitally documenting what was observed in a non-digital, analogue setting, whereby movement is reformulated in the discourse):

C - (Stands up, takes short steps, trunk slightly rigid, sometimes dragging her feet and wandering around in a restricted space.) *Do you see the way I'm walking?*

T - It's as if you were an old lady... as if you only had a small space in which to move around in.

C - Exactly, I'd like to try out music therapy, body expression, do you know of any place? I don't have enough space at home.

Type 7 - Reformulation, integrating feelings with logic:

C - How did I get to be so anxious?... about everything and nothing... And I'm really afraid that Dr. X. will give me more tablets to take, he needs to get me off the tablets, because I need to go to work; I don't know how it's going to pan out, it's not really fear, I feel that when I get there all I'll want to do is pee and have a smoke, because that's what I do when I get nervous... Then I can't do what I'm supposed to, I can't always be going in and out of the work room.

T - But you already know that you get more anxious about what could happen than when you are in are in a concrete situation such as, for example, when you went to that show the other day, when you had that dinner with Joaquina's friends, your aunt's trip from the countryside to Lisbon, when you went to get tests done with your mother.

Type 8 - Reformulation as a means to confront paradoxes (during the client's paradoxical speech, the therapist intervenes to express his or her confusion regarding the paradox):

C - Life's a scary mess... Dr. G., doesn't all this stuff in life upset you as well? The strikes, the Pope, who just adds to the mess, the Maldives war where 500 died. Don't these things bother you Dr. G.?

T - Yes, those are disasters, but can't you accept that I don't just see disasters in the world?

C - Yes, there are good things as well, I just can't see them; for example, observing a rose is a good thing, but I'm not calm enough for that. When my father goes crazy about the roses in the garden and my mother... I just can't be like that.

T - You feel you can only experience bad things, but only a short time ago you told me that music captivates you and that you love to express it through your body.

Type 9 - Extended reformulation with an exploratory focus:

C - (Regarding two sessions the client was going to miss, in a child-like voice the client kept saying that she was a little bit distressed, but wanted to see how far she could go...) *And I can't come on Monday either, because I have Dr. X. at 5 p.m.* (Then, with a hurt tone...) *we won't see each other for a long time*.

T - Indeed, a long time will go by before we see each other again (reflection of the feeling)... *But, do you think there's a relationship between this feeling and the fact that the appointment was set up for the same time as our session?* (reformulation of the paradox).

C - (using an apologetic tone) *It was my mother who set it up*.

T - Do you often feel you have to do everything that your mother wants? (extended reformulation) *Even when that*

stops you from being with whom you want to be with? (exploratory focus)

Type 10 - Reformulation and "heated" interpretation (this seems to us to introduce a certain level of confusion and model contamination):

C - I want to be aggressive and I can't. I feel that Joaquim is destroying me, but I can't leave him.

T - You find it difficult to be aggressive?

C - (suddenly irritated) Yes. Even with you I want to ... (*sits back in the chair) I'm thinking about my father who got angry with my mother's family and I was never allowed to visit my grandparents. He hit my sister for doing it (cries, covers her face with her hands. Shouts) I wanted to tell him what I thought of him but I was so scared that he would send me away.*

T - It seems it's difficult for you to be aggressive with me, and anyone else, because, like with your father, you're afraid I'll send you away.

Type 11 - Affective focus:

C - I was also anxious today before coming for treatment, but now I think that what makes me anxious is leaving the house.

T - In other words, when you leave home, for whatever reason, you always feel anxious?

Type 12 - Semantic focus:

C - (manifests fear of not being able to bear the professional environment, the content of which is in "reformulation integrating feelings".)

(The interaction continues.)

T - And the worst thing that could happen to you is to feel poorly and have to leave the room (therapist's self-expression).

C - But that's exactly what I don't want to happen. I'd like to be able to do everything.

T - What do you think would happen if you were to let go of that feeling of having to be able to do everything?

Type 13 - Experiential focus:

C - (In reply to the semantic focus above) *I'm scared that the same thing will happen as the first time, I was being seen by that doctor, who also gave me medicine, so I was there and what happened? A plane flew overhead and I pointed to the plane but didn't say anything about what I was thinking; I was thinking that I had something to say to the world, I had to say to the world that the world would end and that planes were synonymous with, this is a mess, the evolution of humanity and so-called progress that's going nowhere. And I wanted to say that but I couldn't find the words to say it and so looked like a fool pointing;*

> *T - How does this situation make you feel inside given that even now you are afraid of it?"* (Dias & Caldeira, 1982, pp. 250-257).

These last three extracts of Dias and Caldeira's discourse appear separate from reformulation, though they are related to it. In the cited article, in addition to these examples, the authors provide several comments on different types of intervention.

For Bowen (1987), one of Rogers' direct followers, that which plays a structural and maturative role in empathic responding is the fact that during the transmission of the client's "material" to the therapist, and its subsequent retransmission to the client, what is expressed by the therapist undergoes a certain level of enrichment within the therapist. Thus, this enrichment forms part of the integration, what was "fragmented" will be integrated and, by experiencing it in this way, the client will take full "possession" of a part of him- or herself and move forward in an integrated manner.

At the time of our interest in the concept of insight and its relevance for therapeutic change, and when psychoanalytic culture had a definite influence on our way of being and thinking, we had an alternative reading of the interpretation of intervention/empathic responding. Freud (1972) initially began by trying to interpret the unconscious (what is unconscious becomes conscious); in a second phase, he proposed that the interpretation referred not to what is unconscious but to what is preconscious, requiring it to take place at

an opportune moment. It was not enough for the interpretation to be correct, but, above all, it had to be presented at the right time, at the most timely moment.

Therapeutic intervention, in terms of it being considered as *interpretation* (this concept actually appeared in Rogers and Kinget, 1971a; 1971b), may create a certain level of confusion, implying a close relationship between interpretation and empathic responding. At that time, it seemed to us that empathic responding was an interpretation, not of something unconscious or preconscious, but of something that was already somewhat conscious as it had been expressed more or less explicitly by the client, unavailable as yet in the client's immediate experience.

Today, we feel there is a need to clarify concepts and models, because it is our belief that the confusion in meanings is unworkable and the effectiveness of a model is intimately tied to its internal level of congruence. Notions of the unconscious, preconscious and conscious, as theorised within the psychoanalytic model, are not suited to either the model, nor the language, nor the philosophy of Rogerian thinking. Their use in the context of Client-Centred Therapy or the Person-Centred Approach makes discourse confusing, increasing its level of incongruence.

We find it very interesting how Carl Rogers developed the importance of awareness in the therapeutic process, how he complemented it, as he gradually came to recognise, to experiencing.

In many fields of science, the contributions of quantum theory, often used as a metaphor, can help us to grasp what is going on in other fields. Awareness, insight and experiencing behave as a quantum pair, that is, the more there is of one, the less there is of the other, yet the two always coexist. One aspect may be more highly concentrated and, thus, the other less concentrated, but the two are always present from a relational point of view.

The path taken by Rogers toward the complexification of this concept is due, in part, to his contact with Gendlin's (1978) ideas. As already mentioned, Gendlin felt that the client's perception of the therapist's attitudes of empathic understanding, congruence and positive regard was not a necessary condition for therapeutic change, given that even without the perception of these attitudes it is possible for the client to experience therapeutic change. Thus, emphasis lies not on the perception of attitudes, but on the absolute necessity of experiencing them. From our point of view, it is not clear how one can experience empathic understanding, unconditional regard and congruence without perceiving them.

In the same writing, Gendlin (1978) reaffirmed his "affiliation" with Carl Rogers and called attention to the importance of reformulation and empathic listening, highlighting the need to be aware of the different assumptions underlying our philosophical models, in comparison with others, and the key role played by the therapist of being fully present, as a living being, in therapeutic work. In the context of applying a technique such as focusing, it has been

shown that although a person can achieve favourable results on his or her own the presence of another person, even when that other person says or does nothing, enables better functioning. The *presence* of the other is a catalyst for *my own* progress.

Gendlin (1990) stressed the importance of empathic response in the adjustment of the therapist's perception to the client's perceived reality, stating: "I will follow the client wherever the client takes me and if that is doing something for the client, then I am content" (p. 221). These aspects are frequently described in Rogers's reports, but Gendlin suggests that something unique happens in that moment; a step is overcome: the client usually breathes a sigh of relief, then there is a silence, simultaneously soothing and constructive, during which the interaction continues. The client received an empathic response, he or she felt understood, there was a moment of synchronicity between the client's experience and that of the therapist, and that silence is a structuring silence.

We do not believe that Gendlin wanted to establish himself as the founder of a different school or model of psychotherapy, or even of an alternative to Client-Centred Therapy. On the contrary, what we are given to believe is that he wanted to use focusing as an integrative development, in his opinion integrated in the Client-Centred Therapy model. Indeed, he claimed "client-centered therapy to be the larger thing (...) focusing is a very tiny very important process" (Gendlin, 1990, p. 222).

While the focusing technique serves as an aide to the therapist, enabling him or her to understand the client's experience in a deadlock situation and, consequently, unblock the situation, we find Rogers' (1971) position on client resistance to be of more relevance. Rogers believed that resistance played an important role in maintaining the client's sense of efficacy and psychological safety and this resistance disappeared of its own accord when it was no longer needed, provided the relationship was based on adequate conditions.

In our view, focusing, which was meant to be another form of listening, became a technique, just as repetitive interaction became a non-directive technique, and thus from the moment it became a technique, disembodied and dissociated from the spirit inspiring it, its essence inevitably became distorted.

Some of Gendlin's followers did not think of themselves as psychotherapists, but as teachers of focusing. The helping method became more concrete, it became an end. This seminal article by Gendlin that we have been citing seems to confirm that he did not view focusing as an end in itself.

In a posthumously published text, Rogers (1987b) states that "there was a time when I believed that insight itself was such a crucial element. I have long since abandoned that point of view (...)", going on to say "(...) I have often spoken as if the relationship were the crucial element" (p. 13), and he goes on to develop the fundamental concept called moments of movement, in other words, "(...) I can

hypothesize that therapy consists of a series of moments of movement" (p. 15). He illustrates this by giving an example:

> *Client* - "(weeping) *You know, it's almost a physical thing, it's sort of as though I were looking within myself at all kinds of nerve endings and bits of things that have been sort of mashed.*
>
> *Therapist - As though some of the most delicate aspects of you physically almost have been crushed or hurt.*
>
> *Client - Yes, I do get the feeling, 'Oh!, you poor thing'*.
>
> *Therapist - You just can't help but feel deeply sorry for the person that is you!*"

For Rogers (1987b), these movements "are the most crucial or the most essential element for personality change" (p. 19). According to Rogers, when a previously denied feeling is experienced fully, in its entirety, both at the level of expression and of consciousness, and accepted, rather than being thought of as something wrong or bad, a fundamental and irreversible change occurs.

We synthesise his ideas in the following way: first, what happens is something which takes place in existential movement, it is not thinking about something but experiencing something which occurs in that moment within the relationship; second, the experience is without barriers, inhibitions or any type of impediment; third, it is in a certain way an experience that has repeated itself many times in the past, but was never fully experienced; fourth, this experience has the quality of being accepted. Rogers (1987b) argues that whenever an

experience containing these four psychological qualities occurs in therapy, a moment of change in personality arises.

Referring to the example given, Rogers believed that the client experienced a new feeling. In attempting to define these moments, he did not necessarily equate them with sexual or negative feelings, or even with social taboos. He stated that when people enter therapy they start by talking about the negative things, and only after expressing these do the positive feelings surface. Once such feelings are fully experienced, a number of insights can emerge, though it seems that this change in perception and relationship may be more of a consequence than a basic feature. When the client experiences the safety and warmth of the therapeutic relationship, when he or she feels respected and understood by the therapist, then the conditions for crucial moments to occur in therapy are met. Rogers even stated that in these crucial moments lasting physiological changes occur. In our view, this statement is the starting point for future research.

In the above-mentioned article, it is hypothesised that these moments of change in personality have features which can be defined and empirically, quantitatively verified. In these short periods there is an immediate and existential experience of unity, or wholeness, insofar as an emotion/feeling in the client's physiological system corresponds with a symbolic representation of that emotion/feeling at the level of consciousness and, consequently, is accepted as part of the overall personality. It is a very important and very dense moment, a moment of integration combined with a sense of wholeness. Thus, we

come back to Sartre (1960) and his concept of "totalisation", which in our view can be translated as: that which is perceived in "me" as being partial forms part of the totality.

Through the development of Rogers' thinking, we witness a demystification of reflection of feelings. This ceases to be something magical in itself. It is not the driver of change, the driver residing "elsewhere", probably in the silences that Gendlin talked about, simultaneously in awareness and experiencing. This totalisation/integration is something that has to do with the body, we live with our bodies, we are body in the totality of the organismic experience.

Thus, having striped away the magical aspect an empathic response may have, especially among younger or less experienced therapists, it is imperative that it be *re*-situated. The fundamental role of the empathic response is to maintain the relationship, presence, understanding of the other person from his or her internal frame of reference, to be present in the relationship in an authentic manner, to allow the client to feel and perceive that we understand him or her and, consequently, enable necessary integration, resulting in experiencing insight into the experience through understanding.

Chapter IV

Client-Centred Therapy and its Limitations

In his book, *The Therapeutic Relationship and its Impact* (1967), Rogers put forward his theory of the six necessary and sufficient conditions for therapeutic and constructive personality change to occur in the person. This theory[2] was abstracted from a long-term research project in which therapy sessions had been recorded and, subsequently, significant portions of the transcripts analysed. Initially, and in a spirit of inquiry and pragmatism, Rogers was searching for elements of the therapeutic process that were common among the different psychotherapeutic techniques. However, he ended up establishing the principles of a new therapeutic approach which, after being called Non-directive, became known as Client-Centred, currently also known as the Person-Centred Approach.

Rogers' proposal, in terms of the six necessary and sufficient conditions, served as the basis for a significant number of studies

[2] This theory was first put forward by Rogers (1957) in an article entitled *The Necessary and Sufficient Conditions of Therapeutic Personality Change*, applicable to all therapeutic models. However, in a later article (1959) he restricted this theory to client-centred therapy.

aiming to either empirically test its validity or explore the limitations of its applications.

Let us say that the myth surrounding a "meta-model", the "common-beyond-all-else", continues to persist, as demonstrated by Bandler and Grinder (1975). Using Chomsky's (1957) theory of transformational grammar, these authors analysed the transcripts of therapy sessions directed by the leaders of different schools of therapy, such as Perls (1973), Satir (1972) and Erickson (Erickson & Haley, 1967), therapists considered "charismatic superstars" (p. 5), in an attempt to find the common "structural element" in therapeutic relationships. Despite confirming that they "never had the intention of starting a new *school* of therapy" (1976, p. 195), through their book, *The Structure of Magic II* (1976), they ended up laying the foundations of a new therapeutic approach, known today as Neuro Linguistic Programming. It is our belief that other modern orientations such as, for instance, Integrative Psychotherapy (Erskine & Moursund, 1988) came about in a similar fashion.

In the *Journal of Consulting Psychology* (1957), Rogers spelled out the development of the therapeutic relationship, providing a somewhat detailed explanation of the six necessary and sufficient conditions of therapeutic change, which are listed in Chapter II.

According to Rogers, the therapist is "responsible" for three of these six conditions: *congruence* in the here and now of the therapeutic encounter, *unconditional positive regard* for the client and *empathic understanding* of the client's frame of reference; two of the

conditions depend on both the client and the therapist: *being-in-psychological-contact* and *able to minimally communicate empathic understanding and unconditional positive regard to the client*; one condition is exclusively dependent, at least at the outset, on the client: being in a state of *incongruence*, being vulnerable or anxious.

Congruence[3] acts as a guardian, ensuring there is sufficient space in which both the client and the therapist can be themselves.

Unconditional positive regard means being considerate, accepting the client and what he or she says without passing judgement, facilitating the Other's sense of autonomy, enabling the Other to create and direct his or her own experience towards the resolution, or not, of internal struggles. It means accepting the Other, together with his or her feelings, emotions and way of reasoning, as a whole person, in his or her way of "being-in-the-world", despite any issues we might be experiencing in our own lives. It is to accept the rhythm of change determined by the Other or, even in the absence of change, the path he or she has chosen, one that is different from our own. Unconditional positive regard means showing consideration, a relationship based on equality, not on power, in a warm and caring environment, listening to the Other, a concrete and unique human being, without establishing comparisons or interpretations. By "appearing" to accept the Other, when perhaps "despite myself" in "my" (the therapist's) mind I am judging the Other, I introduce irrelevance into the relationship, rendering it ineffective, and by

[3] Concept developed in Chapter II

"deceiving myself", I end up internalising a contradiction and generating a state of incongruence within "me".

Empathic understanding is a dynamic process, giving the therapist the ability to gain access to the world perceived by the Other, at all times remaining deeply sensitive to movement and meanings in the Other's experience. It is "being able to move around" in the world of the Other, delicately and in a non-judgemental manner, becoming aware of feelings the Other is as yet unaware of, but without unveiling what is still hidden, allowing the other person to discover at his or own pace, while permanently remaining completely open to "awe" and creativity.

Empathic understanding means understanding the Other's internal frames of reference, his or her movements and semantic universe. It means "feeling" the Other's sadness and joy as if we were the Other, but not as if these feelings of sadness and joy were our own, because then our individual identities would fuse and the relationship would evaporate, as would our ability to help the other person. It means listening without *prejudice*, without having a preconceived model to which the client should be reduced. It is establishing connections, a subject-to-subject, person-to-person relationship, not a subject-to-object relationship. It is being fully present in the here and now of the encounter, facilitating change, without substituting the Other as the centre of evaluation, decision and choice.

Following our detailed description of what we mean by empathic understanding, we might ask the following question: *but what does the discourse of the other person mean to me?*

The meaning behind what is being said is not always clear, as slang rarely transcends the boundaries of time and geography and, on the other hand, meanings constantly evolve, because they are not subject to traditional linguistic rules. We can illustrate this through the following: when a client is talking about a *finger*, he or she is not necessarily referring to one of the four slender joints attached to a hand, as defined in the dictionary, or when he or she uses the word *slam*, it might not be in reference to a loud bang. Thus, a relationship based on empathic understanding also involves being able to adequately communicate to the other person our perception of his or her world and "way-of-being-in-the-world", continuously adjusting the accuracy of our understanding through intervention, working with the client to understand the possible meaning of his or her experience and accompanying the client as he or she reconstructs his or her system of references.

Empathy requires a personal analysis of the Other's world from his or her subjective frame of mind, a "for itself" perspective of the Other, as referred to by Caldeira (1979, p. 59) when he presented his model of the social anthropological system. But empathy also requires the important task of becoming familiar with the "in itself" side of the Other's world, the flip side of the coin, the social

anthropological system from a certain "scientifically objective" vantage point.

The three conditions which depend on the therapist may, at first glance, not seem to be very important. Therapists are generally "well-intentioned people", strongly committed to the helping relationship and always ready to "improve their skills" through basic and on-going training. Experience has shown, however, that it is not always easy to integrate these attitudes with therapy, and that specific client populations present challenges which are sometimes difficult to overcome, even for the most experienced therapists.

At the III International Forum of the Person-Centred Approach, held in La Jolla in 1987, there was, at one stage, a discussion of the difficult circumstances being experienced by some of the participants from Chile. One of the therapists, a central figure in the Rogerian movement, world renowned for his expertise in person-centred theory and practice, humbly admitted that he would be incapable of showing unconditional positive regard for the dictator in power at the time, in the "unthinkable" event that he should ask for psychotherapeutic help.

The difficulty in showing unconditional regard for a client, as in the example above, is due mainly to a confusion existing between the client and his or her actions. Accepting the criminal does not mean that one accepts the crime. It means that one accepts the person behind the criminal, the Human Being who is capable of evolving in a constructive and emancipated manner. This notion is expressed by

theologians in the "assertion of faith": *God loves the sinner, but not the sin*. Accepting someone who is different yet, from a cultural point of view, similar to us, someone who shares our moral and social values, may be difficult. But this is certainly nothing compared with accepting someone who challenges our personal values, who unnerves us by the destruction they are causing to our social fabric, who makes us question our safety, physical, ethical, psychological and social, because of a perceived threat to the lives of those closest to us.

We feel it is essential to clearly spell out the framework of the intervention, to reduce our doubts and mixed feelings as much as possible, by clarifying criteria and values acceptable to us, criteria and values which may be integrated with our way of "being-in-the-world". To us, this seems to be the only way in which we can generate the necessary level of trust within ourselves, enabling us to stand before another person, someone who is very different to us, without passing judgement, and be accepting and consistent with who we truly are.

Another aspect that needs to be emphasised has to do with the therapist's difficulty in empathically understanding a person who is very different to him or her, someone with a different culture and who uses a "different language", namely when the person uses the same word in different contexts, words with multiple meanings. The therapist must have a solid anthropological understanding of the culture, particularly contemporary anthropology and that relating to transgressive and deviant behaviour.

Rogers and Truax (1967) showed that client/patient characteristics can influence the quality of the relationship formed with the therapist, stating that it is clearly preferable that both parties have the same social and cultural roots.

The second of the aforementioned conditions depends exclusively on the "client": *the first person, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious*. In the following section, we will address the circumstances under which the client may have difficulty in recognising or accepting his or her state of incongruence.

All schools of psychotherapy that have made it mandatory for their future therapists to undergo personal therapy, either using a didactic approach or as part of the more hazy concept of personal development, have been confronted with doubts and mixed feelings about "treating" those who have not sought treatment voluntarily, who neither feel nor consider themselves to be ill. And by calling oneself a client rather than a patient seems to us, in this case, to be just another way of avoiding the problem rather than representing a true sign of progress towards a solution. It is possible that imposing such a constraint may induce a state of incongruence within the candidate, creating that state of vulnerability making "constructive change" possible. We all know, some from personal experience, how long this period called "pre-therapy" can take.

In his book, *Specialized Methods of Counseling and Psychotherapy*, Thorne (1968) suggested the possibility of the

therapist inducing conflict in the client, as a motivational treatment technique. Earlier, Anna Freud (1974) made a similar suggestion, which we will present further on. We consider pre-therapy to be a key instrument, vital for the treatment of specific populations that, although calling themselves clients, or better yet "health consumers", seek us out not because they consider themselves to be ill, in a state of incongruence or vulnerable, but, above all, because the *world* and *others* around them lack coherence.

In the late fifties and early sixties, Rogers carried out a study to test a number of hypotheses relating to the three basic attitudes of the therapeutic relationship (Gendlin & Rogers, 1967). In the study, the aim was to compare progress through psychotherapy between a group of patients diagnosed as chronic schizophrenics, a group of patients diagnosed as acute schizophrenics, a group of neurotics, a group of so-called normal persons and a control group. One of the hypotheses stated that the same variables of the therapeutic process would characterise in-therapy behaviour, whether of acute schizophrenics, chronic schizophrenics, neurotics, or (so-called) normal persons. This hypothesis was confirmed through experimental research, though therapy with the schizophrenic patients was focused more on establishing the relationship than on self-exploration, the latter possibly never coming to occupy as prominent a position in therapy among schizophrenic patients as it does in the therapy of neurotic patients.

According to Rogers, the therapists were confronted with an unexpected challenge:

> (...) the therapists were new to the task of relating to individuals who had not requested help. They were less expressive, less skilled in initiating a significant relationship than they later became. (...) We failed to communicate to the normal subjects the possibilities which we had hoped they would discover in an expressive relationship (....) They were faced with many difficult problems in establishing a relationship with the hospitalized schizophrenics and likewise with the normals, both of the groups being composed of individuals who were not seeking help (1967a, p. 67).

Gendlin (1967a), who also collaborated on this project, made the following comment: "(...) initiation of psychotherapy is extremely difficult with discouraged, frightened, withdrawn, suspicious patients. Such patients need to see and hear therapeutic relating with other patients and to approach and withdraw from it repeatedly before they can bear to try out such a relationship themselves" (p. 526).

Patterson (1990) also analysed the problem posed by clients he refers to as *involuntary*, clients who, like the participants of the study mentioned above, are not asking for help or who reject help in the manner it is provided to them, namely certain marginalised and/or delinquent populations. In his view, "so-called involuntary clients will

not, or cannot, recognize and accept the understanding, interest and concern of the therapist. They will not or cannot trust the therapist" (p. 317).

In this case, the difficulty during therapy is in upholding the last of the six necessary and sufficient conditions. In Patterson's opinion, "the only solution to the problem appears to be persistent offering of the [necessary and sufficient] conditions until, in some cases at least, they are perceived and accepted by the person to whom they are offered, who then [and only then] becomes a client" (p. 320). Patterson's proposal seems to us to be an implicit introduction to the notion of pre-therapy, something we have already referred to, *presence* in a specific setting and under well defined facilitative conditions. Successful pre-therapy may encourage the person to decide to become a client and enter therapy. In this sense, pre-therapy urgently needs to be regarded as a specific, coded form of therapy that can be used under special circumstances or with certain populations (e.g., drug addicts or those who engage in deviant or criminal behaviour).

The difficulties outlined by Patterson are consistent with those presented by Rogers when he discussed the results of the above-mentioned study: "*Our schizophrenic patients exhibited, in general, a very low level of involvement in the process of change and were decidedly remote from their own experiencing*" (Rogers, 1967a, p. 79). " (...) The absence of conscious motivation constitutes a really profound problem (...). There is a great difference between working

with the consciously motivated client, whether neurotic or psychotic, and working with the person who has no such conscious motive, whether that person is normal, neurotic, or psychotic (....) the absence of conscious desire for help presents a greater challenge to the therapist than the presence of psychosis (....) a relationship with such an individual may become psychotherapy when he chooses to seek help" (Rogers, 1968, pp. 183-184).

Anna Freud (1974) was one of the first therapists to take an interest in the problem of *involuntary* and/or unmotivated clients, from both a theoretical and a practical perspective. Sharing her experience, and referring to a child who comes for treatment without having requested it, and whose opinion or agreement had not been sought, she states that: "(...) the situation lacks everything which seems indispensable in the case of the adult: *insight*[4] into illness, voluntary decision, and the wish to be cured" (p. 6). The child is an unmotivated, *involuntary client* who is unaware of the nature, existence even, of his or her illness. The child arrives at the clinic without knowing why he or she is there, a situation which is very similar to the one referred to by Rogers in relation to the chronic schizophrenic patients and the so-called "normals", and this is the case for most drug addicts or individuals who engage in criminal or deviant behaviour.

Anna Freud came to propose a phase of pre-therapy which she called *a period of preparation* for therapy: "making the small patient

[4] Author´s italics

'analyzable' (....) Converting an unsuitable situation into a desirable one (....) a period of 'breaking the child in' for analysis (...) The further the child's state is from this desirable condition, the longer the preparatory period will last" (p. 7). This psychoanalyst provides examples of the various techniques that were used:

- Creating a parallel between the child's situation and that of other clients known to the child, clients recognised by the child as having problems and needing treatment;
- Drawing on Aichhorn's (1925/1935) experience with delinquent youths, she proposes the therapist take the child's side from the outset and "assume that the child's attitude toward his environment is justified" (freud, 1974, p. 10). Only in this way will it be possible, she states, to work "*with* the child and not *against* him" (Freud, 1974, p. 10), to be able to accompany, listen to and accept the client;
- Reflection: "If he came to his appointment in a cheerful mood, I was cheerful too; if he was serious or depressed, I acted seriously. If he preferred to spend the hour under the table, I would treat it as the most natural thing in the world, lift the tablecloth and speak to him under it" (Freud, 1974, p. 12);
- Demonstrating strength and interest: "If he made faces, I pulled better ones; and if he challenged me to trials of strength, I showed myself incomparably stronger" (Freud, 1974, p. 12);

- Demonstrating usefulness: "I proved myself useful to him in small ways, wrote letters for him on the typewriter (...). In the case of a little girl (...) I zealously crochetted and knitted during her appointments, and gradually clothed all her dolls and teddy bears (....), besides an interesting and useful companion I had become a very powerful person, without whose help he could no longer get along" (Freud, 1974, pp. 12-13);
- Provoking anxiety, spelling out conflicts: "I adopted a somewhat devious and not very honest device to bring him into conflict with this part of his personality [referring to the client's 'ego-sytonic' symptom] (....) In yet another case (...) I suddenly separated off all her 'badness' from herself, and personified it, under a name of its own. This was eventually successful insofar as she began to complain to me of this newly created person and obtained insight into the amount of suffering she endured on account of her" (Freud, 1974, p. 15);
- Manipulating contextual relationships: "(...) I entered into a deliberate battle with the aim of undermining the nanny's influence on the child" (Freud, 1974, p. 16).

Anna Freud proposed that this *preparatory period*, or pre-therapy, was suitable not only for children but also for adults with specific pathologies and with similar behaviour or situations to those of children. For example, in the treatment of a severely depressed patient, there might be a period of pre-therapy "during which the

analyst by encouragement and sympathy with the patient's personal needs will attempt to arouse his interest in and decision for the analytic work" (Freud, 1974, p. 21).

Thus gaining the client's interest by being able "to offer him, at the very outset of the treatment, an especially impressive dream interpretation" (Freud, 1974, p. 21), to underscore his strengths, to "support him (...) and (...) accept his version in all his conflicts with his family (...) we make ourselves interesting and useful", conscious of and using the "power and external authority" of the therapist, "justified by his position in the world and the attitude of other, normal people toward him" (Freud, 1974, p. 22) "(....) would be the elements of a similar preparatory period in the treatment of adults", and even more so if "the adult patient with whom we are dealing is still an immature and dependent being and in this respect is closer to a child" (Freud, 1974, p. 23).

All of these techniques are still familiar to us even if we have, for the most part, forgotten where they came from and use them in a more or less intuitive manner.

Other authors, such as Gendlin (1967a, 1967b), who collaborated on the Wisconsin research project, or Prouty (1990), who conducted an in-depth analysis of the results of that project, believed that the problems encountered by the therapists in the Wisconsin study were related to the first of the six necessary and sufficient conditions: *psychological contact between the client and the therapist*.

Carl Rogers never came to develop the notion of psychological contact as fully as he did the therapist's three basic attitudes. Psychological contact "means simply that they [the therapist and the client] have the minimum essentials of a relationship, namely, that each makes a perceived or subceived difference in the experiential field of the other. This difference may be quite minimal and in fact not immediately apparent to an observer" (Rogers & Truax, 1967, p. 99).

Gendlin (1967b) reflected on the problem of establishing contact with some of the participants in the Wisconsin project and presented some of his ideas on how to develop contact, such as physical "touch, but without it being confusing, sexual-like or frightening" (p. 384). At some point, the therapist may even offer the patient a cigarette, something which at a later stage he might refuse to do, on another occasion, lend the patient some money without asking any questions while later demanding the reason for a new loan (Gendlin, 1967b).

Prouty (1990) carried out an extensive and interesting analysis of the Wisconsin research project. And he stressed that the results of this research essentially showed that:

> 1. Regardless of the reality of therapist attitudes, patients tended to perceive low levels of these conditions. 2. There was no significant difference in experiential process movement over therapy in the schizophrenic group as a function of therapist attitudes. 3. There was no significant difference in

> experiential process movement between treatment group and control group (p. 645).

Gendlin (1967b) said that the poor results led the team to reflect on and question what the therapeutic effect on the patients would have been if, rather than receiving therapy, the patients had received the eleven thousand dollars, the cost of the therapy.

Nevertheless, Prouty (1990) pointed out that: "Where experiential process movement did occur, it was a function of therapist attitudes (...)" and "(...) clients receiving highest levels of therapeutic relationship, experienced the greatest reduction in schizophrenic pathology (...) slightly better rates of hospital discharge and presented improvement on Thematic Apperception Test protocols" (p. 645).

On reviewing the results of the research in question, Tsakanika (1987, cited by Prouty, 1990) stated that "severely disturbed individuals have difficulty perceiving empathic understanding and unconditional positive regard intended from the therapist. Empathic contact is thus not established and the therapeutic process is hindered" (p. 646). Rogers had already reported the tendency of schizophrenics "to fend off a relationship either by an almost complete silence (...) or by a flood of over-talk which is equally effective in preventing a real encounter" (Rogers, 1968, p. 185), prompting Prouty to introduce the need for "a *'pre' relationship* or *'pre' experiential* method" (Prouty, 1990, p. 647).

Expanding on the work of Peters (1986) and Merleau-Ponty (1962), Prouty (1990) developed the notion of psychological contact, the first of Rogers' six necessary and sufficient conditions for therapeutic change to occur, suggesting that in schizophrenic patients: 1 – Reality contact is impaired, which inhibits the sharing of a mutual here and now with the therapist; 2 – Affective contact is impaired, preventing access to feelings and emotions; 3 – Communicative contact is impaired, hindering verbal expression.

This assessment is probably valid for many other clients whose capacity to relate with others has been severely compromised, as is often the case with drug addicts.

Thus, *reality contact* (with the World), *affective contact* (with the Self) and *communicative contact* (with Others) are "pre" conditions for therapy to be functional, a blossoming of psychological contact with the World, Self and Others.

Psychological contact was defined by Prouty (1990) as: "A set of therapeutic techniques [contact reflections]. (...) A set of psychological functions necessary for therapy to occur [contact functions]. (...) A set of measureable outcome behaviors [contact behaviors]" (p. 648).

He thus presents Pre-therapy as a theory and method of intervention enabling psychological contact, necessary for therapy, to be restored.

The therapeutic techniques used (or should we call them pre-therapeutic?) are known as contact reflections, categorised by Prouty

into five different types: 1 – *Situation* reflections, helping to restore and develop reality contact within the client's immediate reality; 2 – *Face* reflections, developing and restoring affective contact by reflecting feelings implied by the client's facial expressions; 3 – *Word-for-word* reflections, developing and restoring communicative contact by reproducing what the client says, word-for-word; 4 – *Body* reflections, developing a generalised "here and now" reality contact through 'body-sense' and by reflecting the client's more or less bizarre movements and postures; 5 – *Reiterative* reflections, developing contact by repeating reflections previously shown to be effective.

In terms of the contact functions, reality contact (with the World) refers to the client's awareness of people, things, places, and events; affective contact (with the Self) relates to the client's awareness of his or her own feelings, moods and emotions; and communicative contact (with Others) is defined as the client's ability to symbolise his or her awareness of reality and perceived inner feelings. Contact behaviours should emerge as a logical consequence of prior developments, the client expressing greater contact with the reality of the external world, with the reality of his or her inner world (feelings), and with the reality of the world of the Other.

A digression into such disparate notions of "pre-therapy" as those of Anna Freud (1974), Prouty (1990) and Patterson (1990), ranging from an attitude of seduction to one of structured intervention, through something which might seem like a warm but passive "waiting for better days" type of presence, is likely to leave one

feeling confused, demotivated, perhaps even bored. The success rate for therapeutic programmes rarely exceeds 30%, and therapists are permanently filled with a sense of impotence, which tends to worsen as the stimulus of the challenge becomes exhausted through repeated failure.

One of the tragic aspects of the drug addiction phenomenon is the repetitive "funnel paradigm" experience: A funnel is an object that is wide at the top and narrow at the bottom, ending in a tiny orifice through which liquid is able to pass, drop by drop. Each drop is more or less the same colour and contains more or less the same volume, drops of liquid resulting from a variety of multi-coloured liquids, provided they can be mixed together. Observing a drug addict, or an alcoholic (another more traditional form of drug addiction), at the beginning of his or her "career", when he or she is "courting" or "honeymooning" with the substance of his or her addiction, we are confronted with a wealth of diversity, personality, disease even. Over the years, this wealth of difference gradually fades and disappears. The regularity of biological phenomena, of psychological effects, or more precisely, of biopsychosocial evolution, slowly takes effect, and it is in the gradual deterioration of this evolutionary process that we will find our "potential clients", immersed ever deeper in the funnel until, at the exit of the funnel, all we encounter are certain stereotyped modes of functioning, often leading us to "believe" that all drug addicts are the same.

José is a about twenty-five years old and has been injecting himself with heroin on a regular basis for six years. He comes for a consultation of his own accord, more or less anonymously, to ask for help. He is in love with a girl who does not know he is an addict, a girl he would like to build a life with. It is very important to him that she does not find out about his addiction and, above all, that he is able to overcome this addiction. We arranged for him to stay at our clinic, where he completed a programme of rehab, without the aid of medication. Still employed, he went back to work after his "holiday" at the clinic. Apart from the support of the therapeutic community, his treatment essentially consisted of a brief, twelve-session programme. When we left the region three or four years later, he continued to appear firmly abstinent to heroin, and well integrated in his work and family lives.

Catarina is forty-two years old, a secondary school teacher married to a university professor, and the mother of two school-age children. At the beginning of the marriage, it is her job as a school teacher that provides the family with its only source of income, while her husband continues his studies. Some months after her husband tells her about an affair and his desire to leave her (which indeed he does, though he quickly returns, without however ending the affair), Catarina tries to commit suicide by inhaling exhaust fumes from the car. She is

hospitalised at the university's psychiatric service where, in the space of a year and a half, she would be admitted for three short periods for depression with risk of suicide and severe secondary alcoholism, which quickly developed on account of her marital problems. Pharmacotherapy, including Disulfiram, turns out to be ineffective, particularly in preventing the patient's almost permanent state of drunkenness, and the husband is, generally speaking, praised for his dedication and patience.

She came to us for a consultation on her own initiative and entered therapy, twice a week without the aid of any medication. Treatment lasted six months and the patient was able to gain perfect control over her consumption of alcohol, imposing, as countermeasure, change on the family's dynamics by abandoning the sadomasochistic relationship with her husband, no longer recognising him as the victim he declared himself to be. Currently, 13 years after treatment, it appears that the patient continues to remain balanced.

Bernardo is a 43-year-old graphic designer. Bernarda, his partner, is younger than him and also a graphic designer, well recognised professionally, but very insecure. Bernarda comes to see us, because she is worried about her inability to remain faithful to her partner, who is becoming increasingly intolerant of her bouts of leaving him, only to return to him days or weeks later feeling terribly guilty for what she did. She would like to

make plans for the future, which include her becoming a mother, plans that seem hard to achieve under these circumstances. During the course of therapy, she gradually begins to talk about her partner's problems: an almost permanent state of drunkenness, heavy use of hashish, the occasional use of cocaine, paranoia and bouts of anxiety and violence while under the influence of hashish, making life distressing and difficult for the patient. Bernarda also smokes hashish on a regular basis, considering herself to be as addicted, psychologically, as her partner, but seemingly better able to "tolerate" it. Although her addiction harms her career, it has not, as yet, posed any major threat to her social functioning and behaviour. Finally, one day she brings her partner with her. Distressed, frightened and suspicious, he does little to engage in the session that Bernarda has invited him to, to help her to overcome the problems she is experiencing. Slowly but surely, as the session progresses, Bernardo relaxes, engages and allows himself to be engaged, and finally asks for help for himself, for his anxieties, his depression, his drug addiction. His physical condition was clearly poor, his state of depression quite pronounced, but his projective symptoms gradually disappeared as he gradually reduced and finally stopped consuming alcohol and hashish. His problem had to do with isolation, almost everyone in the artistic and intellectual circles he and his partner attended was

using drugs, and no social event went without alcohol, hashish or cocaine. Taking stock of the friends with whom he could spend the New Year without being tempted by alcohol or drugs, he only found one, living in Paris, with whom he and Bernarda spent their holidays. Six months after our first encounter, Bernardo gradually entered into a more "traditional" programme of therapy. Six years later, after a relatively amicable separation from Bernarda, Bernardo is married to a younger woman, is the father of a two-year-old girl, and has made positive strides, professionally and in family life. He occasionally sees Bernarda, for professional reasons, and remains in touch with us, a source of reassurance from him, though contact between us has become increasingly less frequent.

Zita is 28 when she is admitted to the small hospital sector we were running, admitted at the request of her psychiatrist from the German university town where she lives, where university-based psychiatric clinics are highly regarded. Hospitalised, which she accepts with mixed feelings, her aim is to overcome her addiction to Tonopan (combination of analgesic and barbiturate) which, on average, she takes 20 to 30 times a day. She comes from a privileged background, but family relationships are quite tense, particularly the relationship Zita has with her mother. Zita was kept away from home for many years by her mother who sent her to several private boarding

schools, some of which expelled her, either for disruptive behaviour or "minor" drug use. Her brother, a doctor and with whom she shared a very special relationship, having dedicated much of his time and effort to her, effort that proved to be useless when individual therapy failed, abandoned her abruptly, practically severing all ties with the patient, a situation that caused Zita much pain and suffering. In addition to Tonopan, she experimented with hashish and LSD, but never became hooked on either of these substances. Her overall physical condition is pitiful, she suffers from severe mental anorexia, but she does not take an active role in her own treatment and it is impossible to work on her state of ambivalence. The results of psychological tests (TAT and Rorschach) point towards a «pathology of schizophrenia». Relationships are perceived as dangerous and persecutory. She uses manic and perverse defence mechanisms during episodes of paranoia or fragmentation, desires for omnipresence and manipulation contrasting with themes of masochism. Zita was hospitalised nine times in the space of six years, during which time her addiction and depression intertwined with somatic issues, mainly in rleation to her drug addiction or anorexia. A miscarriage, which occurred two years after her first hospitalisation, has a profoundly disturbing effect on the patient's psychological functioning. Over the space of seven years, our "pre-therapeutic" activities did not amount to much.

Organizing another stay at the hospital whenever her health deteriorated, to such an extent that she herself requested to be admitted; seeing her once or twice a week, mainly outside of scheduled meetings; upholding an environment conducive to therapy, where what seemed important to us was, as stated by Patterson (1990), ensuring presence, but within the contractual framework we were able to establish and she was willing to accept. Gradually, it became possible to establish boundaries in the relationship, introducing her to the notion of our unavailability to her at certain times, setting limits and presenting ideas such as: not treating her any differently than other patients, not interrupting another patient's session in order to take a call from her, or not cancelling another patient's session so that she could be seen instead. In this way, we became a source of reassurance for her. After a number of years, Zita decided for herself to become a client. Later, in times of heightened tension or discouragement, she would send us news. Ten years later, she was still stable on a low dose of mood stabilisers.

These examples drawn from clinical practice show us that, despite everything, it is possible to shift from a "funnel paradigm" to an "hourglass paradigm"; that, despite the enormous challenges drug addicts pose to treatment approaches, mainly because they are unmotivated,

involuntary clients, it is essential to remain open to diversity. It is often possible, from the outset, to conduct therapy within a "traditional" therapeutic framework, so long as the six necessary and sufficient conditions are present. But it is almost always possible to lay the foundations of a "pre-therapy" either, as Patterson states, in the form of presence, patiently waiting for the moment in which the person decides to become a client or, under other circumstances, by drawing on certain aspects of Anna Freud's thinking or, finally, in a more structured format as proposed by Prouty, a pre-therapy that sooner or later enables the necessary and sufficient conditions for therapy to unfold. And if this is not therapy, what is it then?

Chapter V

Family-Centred Therapy

All the while his thinking was evolving, from the so-called non-directive approach to the Person-Centred Approach in psychotherapy, through Client-Centred Therapy, Rogers expressed a keen interest in groups in general and families in particular.

This area of research caught the interest of some of Rogers' disciples, such as Raskin and Van der Veen (1970), Levant (1978), Barrett-Lennard (1984), Guerney (1984) and Gaylin (1993), as shown by the substantial number of articles that have been published. However, it seems to us that, within the scope of the Person-Centered Approach, family therapy has not received all the attention it deserves.

While Carl Rogers' interest in the impact of social, economic, political and cultural factors on Humans in general, and the "client" in particular, came to be developed in Portugal, especially from the 1970's onwards, these factors always featured prominently in clinical practice and research, particularly for Caldeira (1979), with the family playing a pivotal role in the development of Rogers' person-centred model in Portugal.

At the heart of our approach in family therapy is the socio-anthropological system, a concept initially developed by Caldeira and described in Chapter X, which enables the integration of the person and the "individual" from a broad systems perspective, one that incorporates and transcends the person.

According to Caldeira, the socio-anthropological system involves a two-stage approach: the first refers to the development of the intervention and the "encounter" from a client-centred perspective, and the second relates to a phase of reflection and understanding by applying anthropological methodology to the psychological and psychosocial intervention.

Caldeira described five dimensions or subsystems of relationships that make up the socio-anthropological system: personal/individual, interpersonal, group, organisational and societal. Our research activities and clinical practice have led us to introduce a sixth dimension into this model, the relationship with the Absolute or Transcendence.

We are thus faced with a world, or multidimensional system, comprising interdependent social relationships, different dimensions which vary in terms of their degree of presence and intercorrelation. The person is at the centre of this open system and an element of each of these relationships, a system described from a diachronic-synchronic perspective.

To understand the socio-anthropological system is to understand the concrete Human Being from within the context of his

or her family and sociocultural background, a synchronic-diachronic understanding based on dialogue and six dimensions of listening.

Client-centred intervention, through empathic understanding, can reveal how the person experiences his or her relationships within these various dimensions, that is, the part of the system we call *being-for-itself*. By drawing on key elements from other areas of the human sciences, while we reflect on the socio-anthropological system, the second phase of the process, we are able to build up the other part of the system which we call

being-in-itself.

Being-for-itself and *being-in-itself*, as theorised by Sartre (1984), are two different perspectives of the same person – one stemming from within the person and another from outside of the person. These two perspectives can never coincide, but taken together they complement each other in building up a system which, without intending to reproduce the real person, comes as close as possible to the real person, a perspective closely resembling the "Copenhagen Interpretation" (Stapp, 1972; Gribbin, 1984) of quantum mechanics: uncertainty, complementarity and disturbance of the system by the act of observation.

The Family and the Therapeutic Group

We see the family as an open system – a *holon* (Koestler, 1968) considering its group-like structure – that is greater than the sum of its individual members, a socio-anthropological system of relationships, "saturated" with family members' interactions.

Family intervention, whether for the purpose of establishing a diagnosis, running a community programme or facilitating therapy, is based on research (Caldeira, Mendes, Dias, Almeida, & Rebelo, 1981) which has been enhanced over the last 20 years by experience garnered across a diverse range of clinical practice settings.

The Family as a Therapeutic Group

Families have a number of specific characteristics distinguishing them from therapeutic groups. The therapeutic group has a collective memory, semantics (verbal and non-verbal language) and a way of functioning recognised by all of its members. The therapist will have been involved in the process from the very beginning, from the time when the group was first formed and organised; in other words, the therapist will have participated in the development of all aspects inherent to the therapeutic group. The family, on the other hand, has its own collective memory, semantics (including a non-verbal component which carries important meaning), way of functioning and a pre-existing heritage, *pre-existing* the family

members and the therapist, for that matter, who is thus confronted with unfamiliar territory.

In family life, there is a predominance of circular causality over linear causality without the latter being completely suppressed, and these two patterns of interaction behave as a quantum pair, subject to Heisenberg's uncertainty principle.

The family must be seen as a system in which one family member might manifest a problem within the entire family, but also where the whole family might manifest a problem in one of its members.

When a family in distress is seeking help, help is offered in line with the explicit request made: if the request is made on behalf of the family, then treatment will be offered to the family as a whole – family therapy; if the request is made by the couple, then couple's therapy will be offered; if only one member of the family is seeking help, then individual therapy will be offered.

There are times when the explicit request changes, even during treatment. For example, the initial request made by only one member of the family, the self-designated "patient", may gradually extend to the family as a whole, meaning that the family then becomes the "client".

When the designated patient is a child, it is often feasible, advisable, to suggest a preliminary interview with the whole family. Adolescents, brought to therapy by their parents, are often seen by

the therapist in the company of their parents, at least in the initial interview.

By asking for help, the family attributes to the therapist an imagined higher power and ability to restore the family to its true state, which is one of the aspects of the therapeutic process itself. The therapist has knowledge and skills which he uses to the family's favour, but, beyond being an expert, the therapist is a participant and facilitator of the therapeutic process. In our view, the therapist is the facilitator of change, but the locus of decisions and evaluations always resides in the family.

Family-Centred Therapy

We believe that the basic principles underlying Client-Centered Therapy, developed by Rogers (1959), can be applied to family work, although we are fully aware of the need for further research in this area for more concrete evidence of this.

Based on Rogers' work, we can say that: under suitable facilitative conditions, each person, group or family will experience change, be able to actualise their potential or, what some of Rogers' disciples prefer to call, possibilities.

In Portuguese and in French, the concept of "organism" can refer to either a life form belonging to the plant or animal kingdom, or to a social structure. Facilitation in family work, the catalyst promoting therapeutic change, requires the therapist to exhibit attitudes of congruence, positive unconditional regard and empathic understanding, as described by Rogers (1961). This facilitation expresses itself through the therapeutic work carried out, by which the narrative of each family member is integrated with the discourse of the family, restoring the individual to the family's discourse in a movement that is based on an attitude of acceptance, not on the annulment of the individual or denial of his or her differences.

Facilitation helps to develop person-to-person relationships and, in the context of the family, it respects the family's ability to make decisions, including those concerning every aspect of therapy, namely who should participate and when, the extent to which each family

member should be involved in the process, specific issues to be addressed in sessions, meanings attached to the family's experience, and actions and decisions that will be accepted or rejected.

By conveying warmth and acceptance, the facilitator is able to remain impartial throughout the intervention. He or she constantly strives to stay within the family's internal frames of references, communicating his or her perception or experience, sensitive to the way in which family members express their experiences, to how they perceive their lives and personal plans, to changes that have already occurred and to the meanings the family attaches to these changes. These three attitudes (congruence, unconditional positive regard and empathic understanding) can be a source of learning and self-development for the therapist.

Specifics of the therapeutic intervention

The technical aspect of the intervention must be appropriate to the nature of the group, particularly in the case of this specific group, the family. Empathic understanding, the means by which family members can adjust their understanding of one another in their person-to-person relationships, is placed at the client's disposal, mitigating manipulation.

For example, it could be said that, while the therapeutic framework is always implicitly or explicitly structured by the therapist, its explicit structuring can be used as a form of empathic response, through action. There is always a place and a role for each member of

the family, whether the family member is present or not in the session, provided the family sees itself as the client. The members of the family play an important role in configuring the space in which each session is to be held, each family member having the freedom to choose his or her place, thereby assigning a place to the therapist.

Our experience in family therapy has led us to establish a framework which is not unlike that established for other group therapies, namely talk therapy, psychodrama (Hipólito et al., 1988) or relaxation (Hipólito, Laroche, & Lazega, 1987), although with its own special features.

Often, as in our work with other groups, we videotape the entire session. Facilitation is usually carried out by a team of two therapists, preferably one female and the other male, and one or two observers who assist via a closed-circuit video feed.

This therapeutic framework, which is explained to the family in advance, enhances our ability to intervene, our availability to the family, and our ability to understand and reflect. If this framework is unacceptable to the family, or if sufficient human or technical resources are unavailable, we might agree to downgrade the framework, though this makes intervention more difficult.

Usually, each therapy session lasts for one and a half to two hours. A few minutes before the end of each session, the session is interrupted and the therapists leave the room to engage in a process of reflection with the observers, reflecting on the session and developing a synthesised empathic response for the session, a

response which is then provided to the family. If the intervention is carried out by only one therapist, then he or she alone will formulate the synthesis at the end of the session, as is the case in our work with other therapeutic groups. The purpose of the synthesised empathic response is neither to judge nor to diagnose, nor does it aim to prescribe "homework". It addresses the family as a group and acknowledges the family's existence in time and space. At a conscious level, the synthesised empathic response enables a connection to be established, a continuity between sessions, the integration of each session within the therapeutic process as a whole.

In family therapy, this synthesised response is normally developed by the team made up of the therapists and the observers, who take into account the need to avoid bias and involuntary manipulation on the part of the therapists, recognising the multiple aspects, both digital and analogue, inherent to the discourse within the family system, accompanying the family and being present in the "here and now" of the intervention. The care with which these synthesised responses are developed is, usually, perceived by the family as a sign of the therapists' sense of responsibility towards the family.

After each session, and for about thirty to ninety minutes, the therapists and the observers reflect on what occurred during the session and its integration within the overall therapeutic process, taking into consideration their own experiences, their empathic

understanding of each family member's experience and what was observed in the video recording.

In the case of only one therapist, this exercise is carried out primarily on the basis of the therapist's own experience and the video recording – an extremely helpful tool, even more so than in other types of group therapy.

This moment of reflection and "team learning" includes a discussion of the therapists' attitudes and techniques, namely empathy, congruence, acceptance, favouritism, manipulation and facilitation of communication, among others.

Of particular importance are key moments in which individual family members relate with their family system and the therapists. It is also crucial to avoid any form of reductionism and to take into account, whenever relevant, the different dimensions inherent to each socio-anthropological system, to the family system (as a group, a specific group) and, finally, to the therapeutic system (family, therapists, therapeutic framework).

In summary: Family intervention, through research, theory, community support programmes, diagnosis and therapeutic facilitation, is one of the domains in which critical reflection on experience is most needed, given, on the one hand, the importance of the family in the development of disease and mental health and, on the other, the need to overcome the reign of individualistic ideology that is harmful to the family.

Chapter VI

Person-Centred Therapy and the Body Relaxation Approach

Rogers' position on theory was always one of great pragmatism and openness. He never thought of himself as the holder of an absolute truth, rather an experimental scientist who, on the basis of his clinical practice, developed hypotheses to be tested through investigation. He explored many avenues, but never demanded of his pupils or colleagues a dogmatic attitude that could only be developed through exegesis. On the contrary, on several occasions and in many texts, he encouraged the exploration of new lines of research and of new fields and areas in which to apply his philosophy and hypotheses, such as, for example, brief therapies (Nunes, 1994).

Based on this, one of the areas we explored, developing a novel approach within the scope of the Client-Centred Approach, was that of body oriented psychotherapy, more specifically of the body "in relationship" during relaxation. The current proliferation of body oriented therapies is testimony to a renewed interest in the body, both within the fields of psychotherapy and psychiatry as well as in everyday life.

Humans, as "beings" in the process of actualisation, stand at the crossroads of several worlds, dimensions or systems that, through their interaction and interpenetration, provide sense and meaning to the person's own world, or socio-anthropological system. Our investigation is driven by the search for harmony and integration among the different systems that are present, by the somatopsychic integration of a body, without which psychic life cannot exist.

The purpose of our work is not to develop simply another muscle relaxation technique, or new form of meditation, rather to "chart" a journey exploring the body proper, the exploration of "itself", in the daily battle to achieve freedom, from a client-centred perspective, whether the client is one person or a group of persons.

Many schools of therapy have taken an interest in the body relaxation approach. Relaxation is an ancient technique designed to enhance well-being or spiritual growth. Yoga, developed in India long before the era of Christianity and deeply connected to Buddhist culture, combines psychophysiological technique with mysticism in "a union with oneself through the dense and tenacious application of conscious vitality over a part of the body" (Lemaire, 1964, p. 15).

In western Christianity, the Orthodox monks of Mount Athos also developed exercises based on mental concentration and controlled breathing in the search for "tranquillity of the heart and calm discipline of the mental faculties" (Lemaire, 1964, p. 15).

The German psychiatrist, Schultz (1991), was without doubt the first to introduce relaxation as a psychotherapeutic technique in

contemporary science, experimentally tested and supported by an extensive, in-depth body of research. Schultz developed his "autogenic training" technique from his analysis of phenomena encountered in hypnotic states, examining the sensory impressions experienced by individuals trained in self-hypnosis. Though highly interested in psychoanalysis, which he does not seem to have practiced, he did not attribute particular importance to the relational aspects of healing and their use in the therapeutic process. Schultz's pioneering work played a key role in the history of relaxation and paved the way for a number of other techniques which, inspired by his work, drew on other theoretical frameworks.

Psychoanalysis, first through Ajuriaguerra (1980) and later through M. Sapir (1993), integrated relaxation as a therapeutic method, its development furthered by its use in the treatment of relational aspects. Ajuriaguerra developed the notion of *tonic dialogue* from his research on muscle tone, as an aspect of the nervous system, and its relationship with feelings and emotions, and went on to develop a technique that centred on the doctor-patient "transference relationship", psychoanalytically speaking.

Later, M. Sapir and his colleagues developed a relaxation technique, for individuals or groups, which they called *relaxation by variable inductions*. In this relaxation approach, relationships between the client(s) and the therapist(s) are taken into account and eventually "analysed".

Theoretical Framework and Therapeutic Practice

The method we propose may, from a structural point of view, seem to be the same as that proposed by Schultz (1991), when in reality they have little in common with each other. Our method does, however, employ a progressive approach to exploring the body which, as in Schultz's method, develops (initially at least) from a relaxation of the muscles to the perception of a cool forehead, through perceptions of weight, warmth, breathing and heart rate. The client's experience and the therapist-client relationship are, as in the techniques developed by M. Sapir and Ajuriaguerra, at the heart of the process. Our reflection takes into consideration Caldeira's (1979) concept of the socio-anthropological system and, inspired by existential thinking, it draws on the theoretical framework of Carl Rogers' Person-/Group-Centred Approach (Campiche, Hippolyte, & Hipólito, 1991), as well as on the underlying assumptions of Client-Centred Therapy.

Despite the rigorous nature of the theoretical framework, therapeutic practice is relatively flexible in that it can be with one person or a group of persons, with one therapist or a team of therapists, and with or without observers.

How the person, whether he or she is alone or in a group, experiences his or her world, during relaxation, should be approached as comprehensively as possible. The answers being sought by the client reside in the empathic understanding of the client from within his or her own life, from within the context of his or her family and

sociocultural background; in other words, by understanding the person as a socio-anthropological system.

In terms of the therapeutic relationship, person-centred interventions are characterised by a certain number of attitudes and techniques focused on the individual and/or group, in dialectic relation with reflections on the socio-anthropological system.

Dialogue focused on relationships enables one to gain an idea of how the person, or group, perceives him- or herself in relation to a system or object, by looking at the person, or group, from within his or her own world, whereas more recent methods (e.g., sociology, anthropology or economics) can only provide information on the concrete object. When the perception the person has of him- or herself and his or her world is confronted with the perceptions the external world has of the person, it is important to understand and facilitate the transposition of any possible discrepancy between these two perspectives, aiming to learn about and recognise the complex circularity of life, of the person, of society, all fundamentally interrelated, interwoven, and yet each quite distinct from the other.

During relaxation, the "therapist-facilitator" elects an induction for him- or herself (he or she uses the word "I"), allowing the client to choose from this induction that which he or she can or wishes to do, that is, whatever suits the client. The intention here is to give the client total freedom. By working on his or her own body, the therapist pays attention to his or her experiences, recognising him- or herself through the discourse of his or her body. Thus, the body is

engaged in a discourse, addressed first and foremost to the therapist him- or herself.

In the Client- (person- or group-) Centred Approach, a dialogue is established through which the therapist tries to understand what is happening within the client, following the client's lead, using the client's language, from the inside, from how the client sees him- or herself, and then from the outside, from how the therapist perceives the client.

During relaxation, experience has shown that the boundaries between the person's "inner" and "outer" worlds, between what is "real" and what is "imaginary", become increasingly less defined and that there is a progressive and integrated awareness of the body schema.

The formation of the body schema is closely aligned with the individual's somatic and psychic development, to such an extent that body language and inter- and intrapsychic conflicts emerge in tandem with the formation of the body schema. Children are initially confused by the external world, progressively becoming aware of their bodies, at first in a fragmented manner, thanks to the perceptive data they collect and by imitating the gestures of others. The formation of the body schema is a complex process, the fragmented image of the body evolving into a notion of the whole body, an independent and permanent whole. There are two aspects to the notion of body schema: the external body schema, the *container* we see when we look in the mirror, and the internal body schema, the *content*, partly

through what we imagine in the case of pain, noises and sensations coming from our internal organs. The experiences the individual has lived through can show us how the body schema has been formed and integrated.

Technically speaking, we are embarking on a journey to explore the body, one segment of the body at a time. This *rediscovery* is accompanied by a regression which is more or less robust, enabling a new approach to the body schema through a revised understanding of what the client has experienced, in a supportive and facilitative environment.

The effect of a surface-level and in-depth loosening-up, the feeling of unwinding, followed by the experience of weight and warmth, the perception and integration of different bodily movements and functions, enable the individual to experience this desired state of relaxation as one of wholeness and harmony in terms of the perception he or she has of and for *his* or *her self*.

In therapy, each session serves as an introduction to the next, each stage referring to and acting as a reminder of the previous stage.

Indications

The decision to enter into a programme of relaxation therapy, on an individual basis or in group, is made, in accordance with the theoretical model, by the client who is duly informed by the therapist of all therapeutic resources available, and obviously by taking into consideration the client's exact request for help.

Our clients present a wide range of symptoms, including anxiety and depression combined with motor inhibitions, insomnia, distress and fatigue, functional disorders of the respiratory, cardiovascular, gastrointestinal or reproductive systems, or isolated symptoms such as headaches and migraines.

It is generally accepted that relaxation is especially suitable for people who find it difficult to verbalise their struggles and anxieties, tending to manifest these through their bodies. Relaxation enables a client's issues and his or her experiences to be heard. Through the progressive build-up of trust, the client will be able to look at his or her experience from a new perspective and come to terms with his or her psychological problem.

In the case of group work, in some instances it might be useful to create a balance between different disorders, whereas in other situations it might be more beneficial to work with a homogenous group such as, for example, patients with psychosomatic symptoms (e.g., cardiovascular or gastrointestinal problems) or psychotic patients.

It is preferable, though not absolutely necessary, that the group be mixed and balanced in terms of the gender of the participants. Our experience shows that variance in participants' age is of little importance. Regarding the therapist, he or she should be able to function with ease and be congruent with the intervention.

Descriptive Summary of Clinical Practice

We will now provide a brief description of one relaxation group's journey. The *body-in-relationship* is a stage-by-stage process, a becoming aware of sensations in the skin, muscles and joints, initially one part of the body at a time and then in a more global manner; relaxation, through the growing perception of weight, induces the sensation of *body heaviness*. On an even deeper level of relaxation, this sensation of heaviness leads to the sensation of *body warmth*. The journey through relaxation then continues with the client becoming aware of the rhythm of his or her breathing and heartbeat, in other words, *the body through its own movements*, and through relaxation of the viscera the client gains a sense of his or her internal body schema. Finally, the client integrates the various sensory functions. All through the sessions, *touch* is addressed through tactile sensations, *hearing* through the presence or absence of words, which vary in terms of their rhythm and tone, *smell* through air entering and exiting the nostrils, *taste* by focusing on the mouth and tongue and, lastly,

sight through visual perceptions which are available even when the eyes are closed.

Each of these stages depends, at the outset, on the client's initial state and, once commenced, on assessments carried out before and after each session. Thus, the duration of each cycle and the progression from one cycle to the next can vary substantially; it is always possible to combine two cycles or to repeat a whole cycle before moving on to the next one. The journey through each of these stages enables the internal and external body schema to be developed and assimilated, through the perception we have of ourselves and by confronting this perception with that held by others.

The client engages in a relationship with his or her self, moving from an external plane to one that is internal, passing through the perception of bodily sensations, sliding from the surface to the form, from form to position, from the external body schema to the internal body schema, from a crude relationship with the body to one that is more refined, through the integration of multiple perceptions in the pure wholeness of being. We will provide an example of our practice using the partial transcript of a group's first session.

Most of the clients, presenting a variety of psychosomatic symptoms, had been referred by a general practitioner or a specialist. The group comprising four men and two women would meet at our clinic once a week for a session lasting approximately ninety minutes. In addition to the therapist, psychiatrist and psychotherapist, there were two trainee psychotherapists, sat in a corner of the room, whose

role was to observe the process. Before each session, the team would hold a twenty-minute meeting to take stock of the work that had already been carried out and to prepare for the upcoming session. After each session, the team would meet again, for about thirty to forty-five minutes, to reflect on the work carried out. This group would come to be in therapy for about one year.

The therapist begins the session by explaining the therapeutic framework and by informing the group that it would be joined by one or two more persons in the comings weeks, after which the group would be deemed "closed", meaning that no one else would be joining the group.

The group pays close attention to the information being given. Everyone installs themselves the way they want, sitting or lying on the carpeted floor, but without mattresses or other accessories. The therapists and observers are in a sitting position. The members of the group are told that they may, or may not, experience some difficulty in relaxing their muscles, possibly due to being confronted with "reality"; members are free to express themselves as openly and honestly as they would like on anything they wish to share, such as sensations, feelings, images, thoughts or memories. The group is also informed that nothing that has not been expressed in the group will ever be addressed or explained, regardless of any information available to the therapists. The issue of confidentiality is raised, a duty to be upheld not only by the therapists but also by each member of the group. Group members are free to meet each other outside of

therapy, but in this case, to preserve the group's memory and common language, members are asked to ensure that "anything belonging to the group be given back to the group". Also explained are: the value in practicing relaxation exercises between sessions and the importance of attendance. If any member is unable to attend a session, the group should be informed in advance. The importance of having a member explain to the group his or her reasons for wanting to leave the group before completing the planned course of treatment, is also clarified. Therapy would last for about a year, but the end date would be determined by the group at the appropriate time. Metaphorically speaking, the group's work is a "journey", guided by the therapist through the *body itself*.

The members of the group introduce themselves to each other. Mr. G. complains of problems relating to his gastrointestinal system. Mr. J.J. says he is there for the same reason, as does Mrs. J. Mr. J. explains to the group that he is essentially there for the same reason. Mr. P. talks about his "stress" at work and his "old" stomach ulcer. Finally, Mrs. N. says that she is not yet quite sure why she is in the group.

The therapist begins: (...) *I make myself as comfortable as possible*. The members of the group lie down on the carpet, and all of them take off their shoes, except for Mr. J.

After a few moments of silence, the therapist continues: *I feel calm... serene... relaxed... surrendering myself completely to the pleasure of unwinding, relaxing my muscles and listening to my body...*

I'm focusing all my attention on the sensations I can feel in my left hand... I'm slowly becoming aware of the sensations in the palm of my hand... I'm slowly becoming aware of the sensations in my left thumb... its shape... its volume... its position in space... sensations I can feel at the base and at the tip of my finger.

The observers note that the participants appear to be extremely calm, arms extended along their bodies, legs limp.

The therapist continues: *I'm becoming aware of the sensations in my left hand, in my index finger... its shape, its size, its surface.* Mrs. N makes a discreet movement, but remains calm. Mr. J.J. scratches his nose, trying to move as little as possible. The therapist carries on: *I'm becoming aware of the sensations in the middle finger of my left hand, its volume, its shape, its surface, its position in relation to the rest of my body. I can feel the sensations, deep down and on the surface, at the base and at the tip of my finger*.

Mrs. N. rubs her eyes, and the other members of the group remain calm and still. The therapist continues: *I'm becoming aware of the sensations in*... progressively referring to and naming segments of the upper left limb.

The therapist controls the relaxation of the group members' arms. Mrs. N. appears to be relaxed, as do the other members of the group. No one appears to be surprised. The therapist continues: *I'm calm, surrendering myself completely to a wonderful feeling of peace... of well-being... of deep rest... a feeling I have every time, at any moment... in any situation... anywhere, I surrender myself to the*

pleasure of relaxing... slowly... in my own time, my body is regaining its tonicity... a little like when I wake up in the morning... after a long, deep, restful night of sleep... I clench and unclench my fists... Mr. G. is the first to begin contracting, followed by Mrs. N., Mr. J., Mr. P. and Mr. J.J., while Mrs. J. makes languid movements with her left arm... The therapists carries on: *I clench and unclench my fists, fold and unfold my arms... and my legs... take three or four deep breaths to completely replenish the air in my lungs... to activate the circulation in my belly and lungs...opening my eyes... a little like when I wake up in the morning... after a long night of deep, restful sleep... and once I'm wide awake... I stretch out slowly, careful to avoid any sudden movements, protecting my back...*

Mr. G. is the first to sit up, followed by Mr. J., Mr. P., Mr. J.J. and Mrs. N, while Mrs. J. takes a little longer to sit up. A silence descends which seems to last for minutes, though it probably did not last for more than a few seconds. Everyone appears to be waiting. Mrs. J. coughs, Mr. J.J. sighs, and everyone lowers their eyes. Mr. G. glances sideways, while Mr. J.J. gets a bit agitated, legs and feet stretched out in front of him, just like Mr. J. The therapist sends out small signals to the members of the group, an invitation to communicate, and discreet but warm smiles.

The therapist breaks the silence: *I was telling myself that sometimes it's difficult to... to describe what's going on in our body...* Mrs. J. asks: *Is that a question or an observation?* The therapist replies: *It's what I feel*.

I feel more at ease, says Mrs. J. *Knowing that one is not alone in the same situation is comforting*, responds the therapist. Mr. P. says: *I feel that my fingers are more relaxed now*. The therapist: *Now... after we've stopped... I felt my right arm was more relaxed*, adds Mr. P. *I*, Mr. G. says, *focused more on my right hand, it was heavier*. The therapist intervenes using a slightly questioning tone: *A feeling of weightlessness in your left arm?* Mrs. J. adds: *For me it was the opposite, my hand and my arms felt as if they were wrapped in cotton wool, I couldn't feel them*. The therapist: *As if they were suspended in cotton wool*.

Mrs. J. says: *The cold bothered me, I was very cold... despite putting up some resistance, but I can't do it any other way... despite all my efforts to resist... psychiatry, relaxation that was a bit "snail-paced", I feel quite good*. The therapist: *Despite experiences*... Mrs. N. interrupts to say: *In the beginning I found it hard to concentrate, then I felt a bit cold and at the end I felt fine*. The therapist responds empathically: *A bridge between well-being and*... The therapist is interrupted again, this time by Mrs. J., who asks Mrs. N: *And do you still feel cold now?* Mrs. N says no, that things are better. Mr. G. adds: *When we are feeling poorly, we easily feel the cold. I often feel cold even when it is hot*. The therapist gives an empathic response: *Sometimes we wonder how our bodies work*. Mrs. J. adds: *Even when we understand, we get angry with our own bodies*.

The therapist initiates a second sequence of relaxation by saying: *I make myself comfortable again*... All members of the group

stretch out on the floor. *I'm surrendering myself completely and in all safety to relaxation... calm... serene... I'm focusing all my attention on my left hand... on the sensations I can feel in my left hand...* Mrs. N., whose left hand is covering her eyes, extends her left arm along her body. The therapist continues: *I'm focusing all my attention on the sensations I can feel in the cup of my hand... depth... surface... shape... position... my fist... the area going up to my elbow... sensations I can feel deep down and at the surface, on my skin... calm... very calm... serene... relaxed... becoming aware of the sensations in my whole arm, from my fingertips to my shoulder... the shape... the volume... sensations I can feel deep down and at the surface.* Mrs. N. moves, sighs, breaths deeply. The therapist carries on: *Calm... relaxed... immersed in the pleasure of feeling relaxed, listening to my body... filled with the wonderful feeling I have every time I surrender myself to the pleasure of relaxing my muscles, listening to my body, open to everything being experienced within my body... and slowly... in my own time... I give in to the pleasure of my body regaining its tonicity through four successive stages... in the usual way...* Everyone stretches. Mr. J.J.'s eyes are fixed on the therapist. *Opening my eyes just like when I wake up in the morning after a long, deep, restful night of sleep... my body regaining its tonicity... slowly, I am able to sit up...*

The therapist smiles... J.J. yawns... joints cracking... silence descends... After a few moments of silence, the therapist says: *Our time together is up. At the end of the journey there are issues and questions... and then, little by little, we begin to get to know each other*

through the suffering, the problems, and we realise we are able to share with one another. We may be surprised by what we feel, but we can feel good about ourselves, trust others, ourselves and our own bodies.

The members of the group stand up, put on their shoes, and leave the room in a ceremonious fashion.

Conclusion

The client's journey through his or her body, to explore his or her way of being in the world, involves going through different levels of logic: from one of distrust on initial contact to one of trust and proximity; from a body experienced in a global manner to a body that is formed on the basis of partial and synthesised perceptions; from a body that is foreign to the person to one that is mastered, one that exists through the integration of visual perceptions.

The purpose of the discourse is not to reorganise one's past, but to be able to accept one's past and present in a different way, thereby gaining greater freedom for the future.

Chapter VII

Person-Centred Therapy and the Body-Oriented Psychodrama Approach

On describing possible ways to enhance Client-Centred Therapy, Carl Rogers referred to psychodrama[5] as being particularly promising, saying that: "Therapy through drama is a field which has been little developed. It is noted here because it is a stimulating attempt to use the principles of therapy in fresh ways" (1942, p. 440). Rogers' "invitation" compelled us to carry out an in-depth study to test the applicability of this therapeutic technique, initially developed by Moreno (1965), to the context of Client-Centred Therapy.

We first came across psychodrama during our training in psychiatry, pediatric psychiatry and psychotherapy, a time during which we were fortunate enough to work with prominent experts in psychodrama such as Lemoine (1972), who was a follower of Lacan in

[5] Rogers seems to have practiced psychodrama when he refers to "(...) Theoretical and Demonstration Sessions: Group facilitation through demonstration and discussion (...) Simulated classes for the purpose of learning; Psychodrama; The development of group-related theory; Relationship with the drug environment (...) "(1980, p.161).

terms of psychodrama with adults, or Diatkine (1995), a more orthodox psychoanalyst and expert in child psychoanalysis.

Although, nowadays, Moreno is hailed of having been the first to describe and practice psychodrama, from what might be called an existentialist perspective, the psychoanalytic movement was quick to seize this therapeutic technique and incorporate it in its theoretical framework.

Psychodrama ended up spreading well beyond the boundaries of existentialism and psychoanalysis, adapting itself to the theoretical models it was incorporated by, imprinting it with particularisms more or less unique.

Thus, generally speaking, psychodrama has been used with children, adolescents and adults. Interventions can be carried out with one client and a group of therapists, one client or a group of clients and one or more therapists, this includes the specific theory-driven "imposition" of having a team of therapists, one male and the other female, accompanied, or not, by participant-observers or co-therapists, in line with the theoretical model being subscribed to.

Our development of psychodrama (Hipólito et al., 1988) draws on the philosophy of the Person-Centred Approach, and through our research (Campiche, Hyppolyte, & Hipólito, 1991) we believe we have been able to demonstrate that psychodrama can be integrated, specifically, with Client-Centred Therapy.

In this context, not only is psychodrama a highly valuable aspect of therapy but also a model of training, enabling learning

through significant personal experience – experiencing (Rogers, 1967), a flexible format for learning and sensitivity training, not permissible through talk therapy. We consider it to be a novel way of approaching the dialectic person-group relationship, maximising therapeutic potential and the training objectives.

This model of training and sensitivity training has been used to address interpersonal and professional issues, especially among professionals in the areas of mental health, psychology and education. Our experience has led us to prize this type of intervention for the personal development and training of technicians and teams who work in social psychiatry and with groups.

The groups we train through psychodrama consist of a therapist-trainer, participants and participant-observers. In the specific case of training for future psychodramatists, participants are expected to be able to take on the role of therapist-facilitator, and are thus encouraged to view their training as a form of personal development and means to assimilate the values inherent to this mode of facilitation. Experience in facilitating a group can be acquired by participating in the facilitation, analysis and supervision of subsequent groups. Participant-observers should be trained or experienced therapists or have technical experience, acquired within the scope of community or educational programmes; their specific task is to collaborate with the therapist-trainer in the post-session phase of analysis. Apart from, according to the established rules, having to avoid making any suggestions regarding the theme to be

dramatised, the role and activities of the participant-observers are no different from those of other group members.

These groups can be quite large, provided the number of participants is proportional to the number of participant-observers, making them valuable tools for intervention and training.

As an intervention tool, they can be used in social psychiatry (hospital-based programs, therapeutic communities, mental health communities), group therapy and educational programs.

As a training tool in psychodrama, the methodology applied has been to experience the role of observer-participant and later that of co-therapist. In this way, one might participate in an on-going dramatisation on the basis of one's own empathic understanding – which, when the dramatisation comes to an end, will be confronted with the experiences of the other actors –, facilitate a session and be able to participate in its analysis, all of which are significant learning opportunities in the domain of client-centred intervention. The facilitation and participatory observation of experiential teams can help to improve communication within the teams, as well as help facilitators to refine their own style of facilitation.

Groups may decide in advance on the duration of their programmes, or not, and adopt an open or closed format, depending on their willingness to allow new members to join after the group's "journey" has begun. Groups without a predetermined duration are usually characterised as open groups; though, less often, there are

groups without an established duration that are closed, groups that will decide for themselves when to end their work together.

In our thirty or so years of experience with psychodrama groups we have worked on a number of cases, ranging from groups that are closed and meet for only two or three sessions, generally the case for those interested in learning more about this method, to groups of outpatients that operate for over ten years, with the average "duration of stay" per client being two years.

Sessions are facilitated, understood and reflected on in accordance with a group-centred approach, based on Rogers' perspective, and in line with Caldeira's (1979) socio-anthropological system. A Group-Centred Approach means that the therapist conveys congruence (being his or her true self in the here and now of the intervention, integrating experience as it is lived and, if necessary, able to communicate this experience), unconditional positive regard (non-judgemental acceptance of the client's experience) and empathic understanding (the ability to understand the client's world as the client perceives it and communicating this understanding to the client), basic attitudes that foster a climate of trust and safety, enabling the group and each of its members to actualise their potentials – the opportunity to be authentic, to integrate all aspects of experience, to be the centre of self-evaluation, self-determination and constructive change. Group-Centred Approach also means that, in this case where the client is a group, the focus is on the *group*; nevertheless, never forgetting that the group, greater than the mere sum of its parts, is made up of

persons. This is the solution to the apparent contradiction between focusing on a person and focusing on a group. Taking into account the socio-anthropological system means that the therapist-client relationship is maintained within the group-centred intervention and can be used, at a later stage, to build up the socio-anthropological system of the group.

The socio-anthropological system is a map or model that one is admittedly unfamiliar with, and unable to treat directly in its entirety. The discrepancy between how the client experiences him- or herself and the view the facilitator develops of the client is an important analysis of the socio-anthropological system. This system comprises several dimensions, each of which is irreducible but in interaction with all others, within which the client exists and relates with other socio-anthropological systems (for example, in this case with: each participant, the participant-observer(s), the therapist(s), their scientific and professional organisations, and the institutions governing these). Diachrony and synchrony are equally prized in this process of understanding.

The psychodramatic technique we developed, described in greater detail further on (through the enactment of a significant situation proposed by one participant, discussed and agreed upon by the group, followed by the definition and distribution of roles and, subsequently, the sharing and discussion of experiences), is based on the technique developed by Moreno, but as further developed by other schools (Anzieu, 1979; Lebovici, Diatkine, & Soulé, 1995;

Lemoine, 1972) and fully revised in line with the Rogerian perspective. The techniques are used to develop an open, non-directive (but not careless or passive) relationship where there is freedom for self-understanding and acceptance of the emotional reality of the relationship.

In our view, there are two distinct and opposing moments in psychodrama work: on the one hand, a moment of "disorder" in which each person has the opportunity to state which issue he or she would like to work on or see enacted, and, on the other, a moment in which these issues are ordered in terms of their meaning and relevance for the group as a whole, the intention being to integrate the objective with the subjective. We can say that knowledge comes from personal experience. The person exists through his or her experience, which enables him or her to acquire knowledge and, as such, come to accept his or her self. What I "perceive" or "imagine" gives rise to a new outlook containing the past, the present and the future, but from a "here and now" perspective, allowing me to reconstruct my experience and enabling my perceptual and experiential field to broaden and become liberated.

In addition to the theoretical aspects mentioned, our approach is characterised by technical aspects, some of which either original or modified by the theoretical model underlying our practice.

The group operates from a set of rules that provide structure to the therapeutic framework, ensuring there is ample space to develop a climate of trust and psychological safety, crucial for the

group's development process. These rules, which the therapist explains to the group at the beginning of the "journey", do not stem from a theoretical reflection, nor do they intend to establish a power imbalance within the group, between the therapist and other group members, they are based on empirical evidence of what is indispensable to the framework, as confirmed by years of practice. These rules, designed to foster psychological safety and communication within the group, entail: each participant attending every session; providing an explanation to the group for a participant's absence or decision to leave the group; maintaining confidential everything that is discussed within the group; giving back to the group, information concerning the group discussed outside group meetings; developing new ways of working within the group; deliberating through consensus. The therapist also gives information on practical issues such as the time and place for sessions, whether the group is open or closed, and the duration of the group's programme.

As already mentioned, facilitation is centred on the client, whether the client is a group (more than not the situation), a couple or only one person. The characteristics of this facilitation, particularly concerning groups, were analysed and described in great detail by Rogers (1980). These characteristics underpin the therapist's and participant-observers' interventions, whether they express themselves verbally, as in the case of doubling, or through action, when, for example, an unforeseen character is introduced into the dramatisation.

The issue to be worked on is proposed by one of the participants; the therapist(s) and participant-observer(s) avoid making any suggestions. Several proposals may appear and the group will decide on the specific issue to be worked on through a process of consensus, rather than by "majority".

All participants are engaged, though the level of their engagement varies in accordance with their "status": the participant whose issue is being worked on, the participants who are given roles to play in the dramatisation (this might include the participant-observers), other group members, designated participant-spectator(s), to whom roles have not been assigned but who can intervene at any time during the dramatisation,. The aim of the intervention is to enable participants to express their understanding of what is being experienced or felt, either by doubling one of the protagonists or by intervening as a new character in the dramatisation. In terms of the therapist, he or she is deeply engaged in the process, as a person and not merely as a spectator and analyst of the event. Another important aspect of the work is the group analysis phase, in which participants share and reflect on their experience of the dramatisation.

At the end of each session, the therapist provides the group with a synthesised empathic response that, in addition to addressing the common themes of the session, frames the session within the overall treatment programme, without bias or manipulation. After each session, the team, comprising the therapist and the participant-

observer(s), engages in a process of reflection, the aim being to come to an understanding of the session; in other words, supervisory work is carried out, something we consider indispensable.

The proposal of the situation to be worked on, the ideas of and clarifications by the proponent and the group, and the reaching of agreement on the situation to be dramatised, are all processes which are facilitated by the therapist from a client-centred perspective, and in dialectical interaction with the group, interpersonal and personal relationships that "saturate" group functioning.

Each person is "in relationship" with his or her self, but at the same time he or she is in relationship with the other members of the group, and with the group itself as a system. Beyond the group setting, each person is also influenced by his or her relationships with other persons, groups, organisations and institutions. This tension-generating situation between the various dimensions and relationships that are present evolves into an I-you-us dialectical interaction, transforming a personal proposal/dream into one that is both personal and of the group, a proposal agreed to by each group member, and if not, then it paves the path for a new proposal which, often in dialectical relationship with the "rejected" proposal, will lead to a comprehensive synthesis. The proponent of the theme is inevitably committed, not only because it is his or her proposal, but also because of his or her inalienable presence in the dramatisation, regardless of the role he or she assigns to him- or herself. On the other

hand, the other group members are at liberty to either refuse or accept the roles proposed to them.

The dramatisation is started and ended by the therapist, and the act of ending the dramatisation can be seen as a form of empathic understanding through action, that is, the restoration of an understanding of what is being experienced (a breaking-down of the boundaries of the imaginary or psychodramatic space, a transition from imagination to reality, "exhaustion" of the theme, etc.). Another important aspect of empathic understanding during the dramatisation is *doubling*, a form of active participation. By "doubling" an "actor", a participant can express what he or she thinks is being experienced by the "actor" but which is not apparent in the discourse (similar to "asides" in the theatre), but it can also be because the experience holds personal significance for the participant who is thus "pressured" to intervene.

The introduction of an unforeseen character into the dramatisation can also be seen as another form of empathic understanding through action, and it is undoubtedly one of the favoured types of intervention by participant-observers who are thus able to come to terms with (and in a way, overcome) the apparent contradiction between being a participant and being a co-therapist, reformulating the experience of the dramatisation by the *mise en scène* of a new character.

Once a proposal has been put forward and agreed upon, the group participates in its dramatisation, using options made available,

options which enable group members to manage the level of risk or exposure they are willing to accept.

As soon as the dramatisation ends, a process of reflection begins and develops through the verbalisation of that which is real, not imaginary, and the complex system of relationships we refer to above is once again brought into focus. Emotions, expectations and understandings are expressed and analysed, as is the sense of "awe" unleashed among the group members by the dramatisation. Client-centred facilitation helps to clarify the somewhat vague discourse of the dramatisation, which, despite its apparent disconnection from verbal discourse and preference for bodily discourse, fully integrates it by means of an imbrication, simultaneously digital and analogue.

The video recording of the session allows one to confront an "objective" image of the dramatisation, and it is a particularly useful tool for when, at the end of the session, the group develops an understanding of the discrepancies between the "objective" and the "subjective". The reflection process that is carried out after each session can be recorded for educational and research purposes, and, this being the case, the recording is also made available to those who participated in the process: therapist(s)/trainer(s) and participant-observer(s).

Through the synthesised empathic response, the therapist communicates to the group his or her empathic understanding of how the session progressed and the relationships that developed during group functioning. The therapist points out his or her most significant

experiences within the group as a whole. This synthesised response, as in other group facilitation situations, situates itself at the other extreme of the person-group relationship, acknowledging the reality of the group dimension and its irreducibility to the mere sum of its complex systems of relationships, at the crossroads of which each member finds him- or herself. It integrates the session into the diachrony of the group, and is a synthesis-convergence, a view of the synchronic and diachronic aspects of the group's developmental process. Each session is reflected on and understood through the construction of a model of understanding for each group member and the group, in the here and now and across time, and by taking into consideration, to the extent possible, the personal, interpersonal, group, organisational, societal and transcendent dimensions of relationships, at each moment prizing the dimension or dimensions which hold the most meaning.

In this context, relevant knowledge from other disciplines – such as biology, ethology, psychology, anthropology, sociology, economics – and the experiences of the interpersonal and group relationships are taken into account to construct a model of understanding which, while not the "reality", comes as close as possible to the "reality", and always ensuring that there is ample space and freedom to "be" and to understand.

After the session, in a phase dedicated to reflection and analysis, the therapist-trainer(s) and the participant-observer(s) share their experiences, their understanding of the group's progress and

their critical assessments of interventions during the session, the aim being to "fine-tune" intervention techniques. This phase of reflection and analysis tends to increase the availability of the facilitation team, through a process of self-balancing within the group's movement, and it is also an important learning opportunity for the observer-participant(s), further increasing team cohesion and therapeutic efficacy.

In this exercise, the group acts as the revealer of the different dimensions of the socio-anthropological system. Attention is given to the diachronic and synchronic dimensions of the group's process, its particularities (e.g., leadership, verbal and non-verbal communication), the dialectical relationship with the processes and experiences of each participant, as well as the dialectical relationship with the people, groups, organisations and institutions that are part of the group's significant world. Careful attention is also given to team members' (therapists and observer-participants) attitudes and intervention techniques by relating these to the team members' and the group's experiences, and, subsequently, by reflecting on attitudes and techniques from a personal, technical and theoretical perspective, thereby progressively increasing the effectiveness of the intervention.

Psychodrama differs from group talk therapy on a number of aspects relating to the therapeutic process, which we find important. In group talk therapy, "digital" discourse is favoured to the extent that participants are invited to express themselves freely, this discourse then becoming the focus of a group-driven analysis from which past

and present experiences are then analysed, with emotions and feelings essentially expressed through the spoken word. In psychodrama, communication goes beyond the spoken word, it integrates action, body language, as well as the digital and analogue aspects of the communication itself. In the therapeutic group limited to verbal exchanges, help, participation and change occur through verbal communication, whereas in psychodrama the experiential field is widened to incorporate an emotional experiencing of significant events, through a reconstruction in which the "memory" of the body completes the usual mechanism for actualising past experiences.

By creating and recreating realities, and by "giving life" to one's ghosts, ideas and desires through the dramatisation, one is able to experience feelings and emotions which, at a later stage, can be elaborated on through a process of reflection and sharing with the group, through verbal communication. It seems to us, therefore, that the integration of "words" with "action" in psychodrama make it a more powerful tool for change; in group talk therapy, desire is expressed verbally, whereas in psychodrama not only is desire verbally expressed, but also experientially manifested.

The goal of psychodrama, according to Moreno, is to enable the client to *relearn* spontaneity, lost through socialisation, and the therapist plays an active role in triggering moments of emotional actualisation, which clients are not always in a position to accept.

We feel that manipulating the group in order to provoke intense emotions is not only risky for the client, but it also, as stated by Rogers (1980), undermines the group's development process.

In the case of psychoanalytic psychodrama, as for psychoanalysis in the broader context, notions of the unconscious and conscious awareness are of key importance. Thus, dramatisation is seen as a means by which the unconscious desires of the client can be expressed and represented. The therapist acts as the mainstay for "actors" transference, analysing defense mechanisms and resistance during interpretation.

While Morenian psychodrama focuses on spontaneity, attempting to trigger intense emotions in the pursuit of lost spontaneity, and psychoanalysis is predominantly interested in the unconscious, using techniques specific to this model, psychodrama from a client-centred perspective focuses on actualising the potential of the group and of each of its members, where the therapist, rather than being some magician or god, is a facilitator, facilitating through attitudes of congruence, unconditional positive regard and empathic understanding.

We would like to end by illustrating how we apply psychodrama within the scope of our clinical practice, through an example taken from a group whose therapy lasted for two years. The purpose of this group's therapy was two-fold: personal development and training for future psychotherapists. We will provide a descriptive summary of a two-hour session that was chosen randomly. While the

session is not reported in its entirety, the sequence and totality of the events are maintained, the aim being to illustrate some aspects which we consider to be important.

The session begins with the therapist providing information on the absence of some the participants and participant-observers. After a brief silence lasting about a minute, one of the participants (S1) says that although she did not have anything prepared, she would like to work on the situation of a person who, faced with two or more alternatives, refrains from making a decision so as not to upset anyone.

The therapist (T) clarifies: *A person who is faced with various options but who won't make a decision in order to avoid committing themselves.* Can you be more specific about what you have in mind?

S1 finds this somewhat difficult to do and the group, wanting to help S1 with what she may have in mind, proposes: *Three people are preparing a picnic, two of them have clear-cut ideas, one doesn't. How's that?*

S1 replies: *I don't know* ...

The therapist asks whether the *picnic* is a suggestion for what S1 might have in mind or whether it is a new proposal. The group confirms it is just a suggestion, not a new proposal. S1 continues to experience difficulty in defining what she wishes to understand and see enacted, so the group ends up suggesting that they act it out.

The therapist summarises the whole discussion: *We have the opportunity to work on a situation where one person is having a*

conversation with two others who are proposing different things: one suggests going to the beach, the other suggests going to the countryside. The person hides his or her preference for the countryside and, by attempting to avoid conflict between the other two, ends up being stuck between the two proposals. Does this make sense to you?

S1 says yes, and the therapist asks if there are any other proposals or opinions in the group. As no other suggestions are put forward by the group, S1 accepts the proposal. The therapist asks the other participants for their opinion and the group decides in favour of S1's proposal.

The therapist asks S1 if she would like to provide more details on the location and the characters to be portrayed.

S1 explains that, in her opinion, they are three friends, two of them work together while the relationship with the third is less close. The therapist asks S1 about where the people meet.

S1 – *At one of their homes, the home of the one who wants to go to the countryside.*

T – *Are they there already?*

S1 – *Yes.*

T – *Why?*

S1 – *To decide on where they're going to go.*

The therapist suggests that S1 distribute the roles among those who she would like to see play a part in the dramatisation, provided, of course, they are willing to take on these roles.

S1 proposes that S6 play the role of the person who does not want to commit himself but would like to go to the countryside, and that S7 play the role of the person who wants to go to the beach; S1 retains the third role for herself. Everyone agrees with the proposal and the dramatisation can begin. The dramatisation lasts for about twenty minutes. Although we do not include the transcript or summary of the dramatisation here, we would like to point out that a high level of doubling[6] was carried out by the participants.

The therapist, after ending the dramatisation, invites the "actors" to share their experiences of the enactment. The "actors" talk about the difficulties they experienced in being able to play out their assigned roles in the way that these had been defined. Feelings that surfaced during the enactment and the way in which interactions were experienced are explained and analysed. S1 says she felt contradicted, and the other two "actors" also talk about their having felt contradicted. The therapist asks about how the proliferation of doubling was experienced.

S1 – *When S5 came over to me, I didn't know what he wanted. I heard what he said and repeated his words without trying to understand what they meant.*

[6] We define "doubling" as the technique in which a person/participant places him- or herself behind one of the characters in the dramatisation and explains what he or she thinks the "actor" is thinking, the person/participant acts as "auxiliary ego" to one of the "actors".

T – *There was an intense need to intervene from the outside, for doubling, a series of thoughts were not getting through, and at an ever-increasing pace.*

S7 – *I felt that they* (S1 and S6) *were plotting against me.*

S5 – (auxiliary ego) *that became clear to me*.

The group reflects on what has happened, through dialogue with the "actors", and group members talk about their feelings towards the dramatisation. The group reaches the conclusion that the roles were not acted out in the way they had been defined. Roles had been reversed and there was a disconnection between the initial proposal and the final outcome. Together, the therapist and the group work on the reason behind the disconnection.

The therapist suggests they watch the video that was made of the dramatisation, after which he raises a number of technical issues concerning the way in which doubling was carried out, underscoring the difficulty in being able to understand what auxiliaries have to say if they do not speak out loud and slowly. The "actors" and the group go back to reflecting on the disconnections, highlighted by the video. The therapist ends the session by giving a synthesised empathic response:

T - *My feeling, and I am not sure whether you share this feeling, is that none of the three is happy. The initial problem of the person who wanted to get on well with everyone was not resolved, it was postponed. Three keywords emerged: winning over/convincing/condescendence. To me, feeling convinced is certainly*

quite different to feeling won over; in reality, there was no winning over or convincing going on, rather something that appeared to be unacceptable to the people: condescendence, being looked down on. Thus, that which was not acceptable could not be experienced.

The feeling of being looked down on was harder to accept than the feeling of having been won over or convinced. When we are trying to resolve our problems, we often, consciously or unconsciously, resort to tactics of seduction and manipulation, which we then come to fear because of the power they hold. Power we want to break away from, but the harder we try the more entangled we become. In reality, it was an unsatisfactory situation for everyone. The desire to satisfy the needs of others meant that our needs, and those of others, were not met. The question I ask myself is whether this didn't all start right at the beginning, in the manner in which the theme was chosen, that is, when we were all asking each other "how's that?" and "does this make sense to you?". The dramatisation and its outcome were a kind of crystallisation of what went on earlier, when you (S1) were probably not satisfied with the way in which the group "supported" your proposal, support based more on condescendence than true conviction.

Thus, without detracting from Carl Rogers' thinking and philosophy, and inspired by his spirit of openness to research and new paths – he who stated that "the facts are always friendly", we think we have successfully contributed to the integration of an undeniably valuable therapeutic "tool" with the Client-Centred Therapy model.

Through its use in our clinical practice, both in therapy and in what we commonly call "psychodrama for professionals", it has shown itself to be of great value and utility. Psychodrama for professionals has been applied to the contexts of education, in work relating to teacher-student relationships, health and business management.

We also feel that, through our study, we have been able to demonstrate that this way of working with psychodrama is consistent with what we might call an "orthodox" perspective of Client-Centered Therapy, which, according to Barbara Brodley (1990), is based on the hypothesis of the actualising tendency, the six necessary and sufficient conditions for therapeutic change and the non-directive approach.

Chapter VIII

The Centred Approach and Education

The psychotherapeutic relationship seems to be a particular type of helping relationship, a learning relationship, though with special qualities. Rogers (1978a), for instance, referred to therapy as an interpersonal learning relationship and considered therapy to be a form of education.

In Portuguese, the verb to *learn* is unambiguous. When *I learn*, this implies a *you* or *someone who teaches*; *you learn, I teach*. "Learning implies an asymmetric relationship, unknown knowledge or true knowledge, capital, capable of being transmitted through a strange business-like transaction wherein the supplier or seller of the "knowledge" can maintain the capital intact, but transforms the relationship of power implied by the capital.

Unknown knowledge, knowledge not yet spelled out, can be the source of power, a power which fades as soon as the knowledge is shared and becomes known. Sharing knowledge can mean losing power, but it can also bring greater prestige which, in turn, can be converted into power; either way, it depends ultimately on the level

of trust within the person who opens him- or herself up to others, as well as on the quality of his or her knowledge "(Hipólito, 1985, p. 17).

In other languages such as French, for example, the verb to *learn* is ambiguous. It can mean to learn or to teach, to instruct or be instructed, to inform or be informed. The ambiguous nature of the verb in a certain language does not necessarily mean that there is a specific way of learning in that culture, but, at the very least, it does suggest that someone who teaches can also learn, learning through teaching.

Here are two short examples of learning:

> *– Daniel is 19 years old and in his first year of secondary school. Rumour has it that half the class must go due to staffing issues. The environment has become unbearable. Those who know things keep their mouths shut. The less knowledge one shares with one's colleagues, the greater one's chances of not being asked to leave.*
>
> *After a practical physics class, during which students tried to hide their findings from one another, he wrote in his report that: bearing in mind the exercise in physics today was supposed to be a team effort, the circumstances under which the work had to be done are absurd.*

Who has been alienated, Daniel or the system? The second example is personal:

– As a second-year medical student, I was introduced to one of the team leaders of the Emergency Department at Santo António hospital in Oporto (Portugal), who welcomed me as a younger colleague, calling me doctor. Over the years, every week from 1:00 p.m. on Saturdays to 1:00 p.m. on Sundays, I learned about the fundamentals of my profession. I always felt the presence of my experienced companion by my side, conveying his knowledge to me, who, above all, knew how to teach me to learn. Medicine gained life for me; the patient became a person, not a case or an object, and I was never again able to adapt to the traditional higher education system, which did not stop me from enjoying a professional career and which, probably, aroused my passion for different ways of learning.

We would like to take this opportunity to express our gratitude to our colleague, Dr. Domingos de Oliveira Santos.

Based on his experience of teaching literacy skills to the "masses", specifically to the underprivileged in Latin America, Paulo Freire (1968/1974) defined a "non-banking" concept of education through dialogue: education-liberation. In terms of its praxis, the "non-banking" concept of education involves techniques and attitudes. While it is not our intention to enter into the details of the technique,

it is worth recalling the three main aspects of his "critical consciousness" method.

1 – Inventory of the semantic universe of the workers with whom the educators will work, established *a priori* through a survey;

2 – Identification of keywords according to the interest they present in terms of their syllabicity, increasing phonetic difficulties and semantic richness;

3 – Creation of situations reflecting the day-to-day reality of the group the educator is working with, through presentation and discussion of the keywords.

Techniques are but useless instruments when they are not integrated with a set of coherent attitudes, such as energy and drivers of change. In the "non-banking" education system, the educator identifies his or her efforts with those of the students, orienting themselves towards their common humanisation. The educator is there to promote authentic thinking and not to transmit knowledge or a "gift". His or her efforts are imbued with a profound trust in human beings and their creative power, and the relationship he or she establishes with the student is one of camaraderie, a person-to-person, subject-to-subject relationship. The teacher is a subject who knows, transmitting what he or she knows through dialogue with the

subject-student. Knowledge ceases to be a possession and becomes the object of reflection, for both the educator and the student.

The student is an investigator-critic who is in permanent dialogue with the teacher-investigator-critic. The latter continually reconstructs his or her knowledge through dialogue with the student, and integrates joint reflections. In Paulo Freire's (1968/1974) opinion, the mission of the teacher is to provide the conditions for learning to take place.

The actualisation of the student's potential is facilitated by and through dialogue. Dialogue cannot exist without a deep sense of love for the world and human beings. As the foundational aspect of dialogue, love itself is dialogue and, for Paulo Freire, dialogue is humility, acceptance of others, requiring trust in humans and faith in their ability to construct and reconstruct, to create and recreate. Dialogue cannot exist, he says, without hope, authenticity and critical thinking, without rejecting the notion of a dichotomy between human beings and the world. Dialogue is cooperation between subjects; it is unity, organisation and cultural synthesis.

In terms of techniques and attitudes, Paulo Freire's concept of "non-banking" education is similar, if not identical, to Rogers' experiential learning, which we will come back to later.

While dialogue is the driving force for learning, for Paulo Freire it is antidialogue that structures the "banking" education system, characterised by anxiety (a subject-to-object relationship), division, manipulation and cultural invasion. In and outside of school, and at

every level of education, teacher-student relationships are fundamentally narrative in their nature, the teacher being the narrating subject and the student the passive listening object.

According to Paulo Freire, narration tends to petrify words, depriving them of reality and meaning, and discourse is nothing more than noise. The narrator fills the "empty-container" student who then becomes a "full-container" student, and education is nothing more than a process of "deposit-making". Rather than communicating, the narrator issues "communiqués" and makes "deposits". Students can only receive, keep or store these "deposits". In reality students are being "stored", but they are left with the impression that they have the freedom to become collectors or archivists.

In the "banking" education system, knowledge is seen as a gift to be bestowed by those who consider themselves "knowledgeable" upon those whom they consider to know nothing. This "gift" is based on one of the active principles of the ideology of oppression, the "absolutisation of ignorance", ignorance that can always be found in the Other. The educator knows, whereas the student does not know, he or she is ignorant. Ignorance is the *raison d'être* for the existence of the educator, and vice versa. In the world of the "banking" education system, Freire (1968/1974) considers that:

> (a) the teacher teaches and the students are taught; (b) the teacher knows everything and the students know nothing; (c) the teacher thinks and the students are thought about; (d) the

> teacher talks and the students listen–meekly; (e) the teacher disciplines and the students are disciplined; (f) the teacher chooses and enforces his choice, and the students comply; (g) the teacher acts and the students have the illusion of acting through the action of the teacher; (h) the teacher chooses the programme content, and the students (who were not consulted) adapt to it; (i) the teacher confuses the authority of knowledge with his or her own professional authority, which he or she sets in opposition to the freedom of the students; (j), the teacher is the Subject of the learning process, while the pupils are mere objects (p. 52).

Implicit in the "banking" concept of education is the assumption that people are objects *in* the world, not *with* the world or with others. In his critique of the "banking" education system, Paulo Freire points out that there is no good in saying that humans are people, people who are free, when in reality nothing is being done to support this claim. According to Freire, the greatest task of those who are oppressed is to liberate themselves and to liberate their oppressors.

Carl Rogers, through his psychotherapeutic practice, also took an interest in the learning process and in the facilitation of conditions for learning to take place. While not carrying out such an intense and in-depth review of the traditional teaching method, as that of Paulo Freire, Rogers referred to it as a learning of meaningless and irrelevant

things to the person as a whole. As an alternative to this petrifying, stiff and alienating way of learning, Rogers proposed experiential learning, a source of freedom and driver of personal and collective development. For him, learning only has meaning when it is experienced by the person-as-a-whole, when it serves the person's own needs and choices.

According to Rogers (1978a), significant or experiential learning implies personal involvement (the person as a whole participates in the learning process), penetration (the process provokes change in behaviour and attitudes, and sometimes even in the educator's personality), and self-evaluation (the essence is in the meaning).

Significant learning, Rogers said, depends more on attitudes than on techniques. For him, techniques are of secondary importance, to be employed as and when necessary, whereas attitudes are essential and universal. Coherence with oneself in the here and now of the intervention, commitment and conviction are all essential factors without which the self-direction and freedom to learn, given to students, can lead to total failure. Rogers defined a number of conditions or intentions to help foster inner freedom: dealing with a real problem; confidence in the human organism; acceptance; authenticity of the teacher; empathy; and the provision of resources.

These conditions are matched with qualities of the teacher-facilitator, that is, attitudes which play a role in structuring the

relationship, though sometimes these can be simulated, making them mere techniques.

According to Rogers, the generalisation of significant learning would result in abolishing: teaching (those who want to learn would simply get together); exams (these, in his opinion, could only evaluate an inconsequential type of learning); diplomas (given as titles of competence); the process of presenting conclusions (because he believed that no one could acquire significant knowledge through conclusions).

Rogers extracted a number of principles from his own practice: (1) human beings have an innate potential for learning, a potential which can be blunted by mixed feelings or distress experienced in past learning; (2) significant learning occurs when the subject matter is perceived by the student as being relevant for his or her own purposes; (3) learning that involves change in one's sense of self-organisation, in how one sees oneself, is perceived as threatening and tends to be resisted; (4) learning which threatens the self is more easily perceived and assimilated when external threats are at a minimum; (5) when threat to the self is low, experience can be perceived in different ways and learning can proceed; (6) learning is facilitated when the student participates in the learning process in a responsible fashion; (7) *Self-initiated learning involving the person as a whole, his or her feelings and intellect, is the most lasting and pervasive type of learning*; (8) Independence, creativity and self-reliance are all facilitated insofar as self-criticism is basic and evaluation by others is of secondary

importance; (9) the most useful type of social learning in modern society is that of the learning process itself, permanently remaining open to experience and to the process of inner change.

One might say that it is the journey, and not the destination, that counts. Rogers describes the qualities of the teacher-facilitator in the following way: t*he facilitator influences the climate of the group and the classroom experience*; *the facilitator helps to elicit and clarify the purposes of each individual in the class, as well as the more general purposes of the group*; *he or she relies on each student to implement those purposes which have meaning for the student, as the motivational force underlying significant learning*; *he or she endeavours to organise and make easily available the widest possible range of resources for learning*; the facilitator sees him- or herself as a flexible resource who is at the group's disposal; *responding to expressions by the group in the classroom, the facilitator accepts the intellectual content and emotional attitudes of these expressions, endeavouring to give each of these aspects the degree of importance they have for the group or the individual*; when a climate of acceptance has been established in the classroom, *the facilitator can progressively become a participant-learner, that is, another member of the group who, like any other group member, can expresses his or her views*; *the facilitator takes the initiative to share his or her own thoughts and feelings with the group, not in a commanding or imposing manner but simply to participate, which students can either take or leave*; *in the classroom experience, the facilitator remains permanently attuned to*

expressions of deep or strong emotion; *in his or her role as facilitator of learning, the leader endeavours to recognise and accept his or her own limitations.*

At the outset, significant learning may seem to be framed within the traditional mould of the teacher-student relationship, that is, a subject-to-object relationship. The leader has personal authority, given to him or her by the institution. He or she may wish to share this power and create a climate of openness to facilitate the students' freedom. However, this desire must be echoed by the students. To quote Rogers: "It does not seem reasonable to impose freedom on anyone who does not desire it" (1978a, p. 137), thereby opposing educators who, as enlightened vanguards, wish to impose their ideas of happiness or freedom on others.

But, what might thwart a student's desire to be free, to be the subject and not the object of the learning process, to be regarded as a whole person and not as an empty vessel to be filled with knowledge? Rogers believes that in order to gain the love of significant others, of those who are vital to our survival, we abandon our own evaluation processes; the centre of life, of our lives, shifts from us to others, and we live according to the desires and values of others, relying increasingly less on our own ability to evaluate and make choices. We become fearful, insecure and cling to the values of others.

The evaluation process can be returned to the centre through the facilitated discovery, by the teacher and the student alike, of the fact that: within the human being there is an organic basis for an

organised process of self-evaluation; this process of evaluation within the person is efficient in the actualisation of the person's own potential insofar as the person opens him- or herself up to the experience taking place within him or her; in persons who move towards a greater openness to their experiences there is an organismic similarity in the directions of values; these similarities in the directions of values are of the kind that highlight the development of the individual him- or herself and of others within the community, and they contribute to the survival and evolution of the species.

Once the learning process has been initiated, full personal commitment is required to ensure that learning is retained. In his book, *Chemins da la Liberté*, Sartre (2007), through the character Brunet, asks: "what good is freedom without commitment". And Rogers said that: "personal commitment is a total organismic direction, involving not only the conscious spirit, but, equally, the direction of the whole organism" (1978a, p. 242).

Experiential learning has a profound effect on those experiencing it, bringing about change in their *way of being* in the world and in their personal values. Facades, presumptions, defensive attitudes, and "masks" are values which gradually tend to be evaluated negatively. Pleasing others as an end in itself gradually fades away, as does the uncritical acceptance of impositions from the environment. There is an appreciation of the authenticity of self-direction, of one's own perceptions and feelings, of oneself. The "process" is valued above that which is "static", as is openness to experience in one's inner

world and in the external environment. Caring for others, accepting them, being sensitive to others are all valued positively, as are relationships with depth. The processes, objectives, and changes experienced in significant learning, or "non-banking", are similar, if not identical, to those experienced in therapy. This is how Rogers (1961) described therapy and its results:

> I should make it clear from the outset that this experience I have gained comes from the vantage point of a particular orientation to psychotherapy which has developed over the years. Quite possibly all psychotherapy is basically similar, but since I am less sure of that than I once was, I wish to make it clear that my therapeutic experience has been along the lines that seem to me most effective, the type of therapy termed 'client-centered' (....) If the therapy were optimal, intensive as well as extensive, then it would mean that the therapist has been able to enter into an intensely personal and subjective relationship with the client – relating not as a scientist to an object of study, not as a physician expecting to diagnose and cure, but as a person to a person. It would mean that the therapist feels this client to be a person of unconditional self-worth; of value no matter what his condition, his behavior, or his feelings (...) It would mean that the therapist is able to let himself go in understanding this client; that no inner barriers keep him from sensing what it feels like to be the client at each

> moment of the relationship; and that he can convey something of his empathic understanding to the client. It means that the therapist has been comfortable in entering this relationship fully, without knowing cognitively where it will lead, satisfied with providing a climate which will permit the client the utmost freedom to become himself (pp. 184-185).

For the client, optimal therapy means an exploration of increasingly strange, as well as unknown and dangerous, feelings in him- or herself; this exploration proving possible only because the client gradually realises that he or she is accepted unconditionally. Thus, the client becomes intimately acquainted with elements of his or her experience, elements which in the past were denied to awareness, because they were too threatening, too damaging to the structure of the self. The client finds him- or herself experiencing these feelings so fully, so completely, in the relationship, to such an extent that at any given moment he or she is his or her own fear, anger, tenderness or strength. And when the client lives these widely varying feelings, in all their degrees of intensity, the client discovers that he or she has experienced him- or herself, that he or she is everything he or she feels. The client sees his or her behaviour changing in a constructive manner, in accordance with his or her "self" that is experienced in a new way. The client comes to realise that he or she no longer needs to fear the experience, because it will pass, but

embrace the experience freely as a part of his or her self which is undergoing change and developing (Rogers, 1961).

Thus, we can expect that at the end of therapy, the client-patient, just like the student, will be open to his or her own experience, living life in an existential manner and seeing his or her organism as a reliable means of arriving at the most satisfying behaviour in each existential situation (Rogers, 1961).

If we take a closer look at the similarities and dissimilarities between learning and therapy we will see that, while techniques vary in accordance with the specific aim (to facilitate learning and the appropriation of knowledge or to alleviate suffering and promote a sense of well-being and quality of life) and the characteristics of the client, that is, whether the client is a student or a patient, the attitudes that structure the relationship are the same in both cases. Namely, congruence, unconditional positive regard for the client (which does not mean that the client's actions must be accepted), and empathic understanding of the client through active listening. Using techniques without exhibiting these attitudes is a recipe for failure, and although these attitudes can be developed, they must be embodied in a deep and genuine manner. "Fake" attitudes are nothing more than techniques, useless techniques.

Embodying such attitudes requires taking a personal stance, committing to the Human Being; the concrete, living Human Being who becomes by doing, structuring his or her self as he or she structures the world, the author of his or her own life on the physical

plane and creator of his or her own essence. Coherence with oneself in the here and now of the intervention is not possible without the deep and genuine embodiment of this attitude. Unconditional positive regard is only possible insofar as the therapist is able to show respect for the person, for the person's path in life, for the person's capacity to fulfil his or her potential, and respect for the person's own responsibility as a human being. It means accepting someone as a Person, without being forced to accept their actions. As the religious saying goes: "God loves the sinner, but hates the sin". Pretending to accept someone, when judgements are being made internally, introduces irrelevance into the intervention, rendering it ineffective, and self-deception leads to the internalisation of a contradiction.

Empathy is delicacy, it is care, it is moving around in the world of another person in a non-judgemental, non-critical and non-threatening manner, being sensitive to change and to how the Other feels, attempting to understand the movement and allowing the Other to explore at his or her own pace. It is also accepting the Other without change or at the rate of change of his or her choosing, or, moreover, on the path he or she has determined, a path which is different from our own. Accepting the person as and how stated by José Régio: "I only know that I will not go there!" (Régio, 1925, p. 59).

As already stated, empathy means understanding the world of the Other as he or she understands it, seeing it as he or she sees it, as if we were looking at that world through the Other's eyes, through a common language. But what does the Other's narrative mean to us?

When a patient tells us that he or she was born on an island and talks about his or her insular world, is he or she referring to being an islander or to a feeling of isolation? When someone talks to us about witches, is he or she delirious or are witches a concrete reality in the culture of that person? And where is reality? And who can say what is real?

Empathy requires a personal analysis of the Other's world from his or her subjective frame of mind, a "being for itself" perspective of the Other, as referred to by Caldeira (1979, p. 59) when he presented his model of the social anthropological system. It also requires becoming familiar with the "being in itself" side of the Other's world, the flip side of the coin, the social anthropological system from a certain "scientifically objective" vantage point.

It means being familiar with the culture in which the individual developed; the institutions he or she is governed by, relationships in the workplace, in short, getting to know as much as possible about the dimensions and frames of reference inherent to the world of the individual.

Therein lies the art of therapy, in reducing the discrepancy between the two perspectives, the "being in itself" and "being for itself", of the socio-anthropological system, in creating a common language, in building a facilitative climate together with the student by which both parties can actualise their potentials and each can enrich the other through mutual learning, in creating a space that provides freedom and that is liberating, both for the student as well as the facilitator.

Chapter IX

Group Dynamics

Working with large groups, which sometimes incorporated hundreds of participants, led Carl Rogers and his colleagues (1983) to organise experience-based workshops, using a methodology that was based on the dialectic relationship between work in small groups and work in community meetings, proposed to all participants.

In Portugal, Caldeira (1968) was among the first to present and facilitate encounter groups, attended by professionals from the fields of education, nursing, psychology and medicine, among others. Following his lead, some of Caldeira's colleagues also facilitated encounter groups, thereby helping to create greater awareness of the principles underlying the Person-Centred Approach.

The "Encounter Group" workshop to which we are referring, the first of many we were able to facilitate or supervise, was designed to provide a meaningful personal experience to those wishing to participate in this type of experience. The participants came from different professional backgrounds, namely education, health and

psychology, and some of the participants were psychotherapy trainees.

While we were reflecting on this workshop, we became aware of experiences which we called the "point of arrival" – experiencing the encounter with one's self and with others – and the "point of departure" – the conviction that change is possible through what has been experienced.

It was suggested to the group that the work be carried out by alternating between community sessions, the large group incorporating all participants, and small group sessions, which involved dividing the participants into a number of small, equal-sized groups.

In the large group, to encourage communication, the participants proposed themes and defined the ground rules for how the group would function, and, initially, participants seemed to be more interested in putting forward ideas for the workshop than in expressing their own feelings.

When participants transitioned to the small groups, the group atmosphere gradually became less stilted, with verbal and non-verbal communication increasing rapidly among the participants, enabling the group encounter to be experienced by all. Thus, it became increasingly more possible to express one's personal feelings, though when it came to the topic of love, the group felt the need to take a specific approach, that is, when someone talked about love, he or she

was treated in an aggressive manner, and on talking about the aggression received, he or she was loved.

We became aware of an alternating movement which acted as the common thread between the large group and the small groups. Sometimes, even when there was conflict and a breakdown in cohesion, when participants transitioned from the small groups to the large group, it was possible to re-establish communication on another level, the common thread coming to the fore and once again acting as the binding element within the small groups, leading to the movement we defined as the "point of arrival" – enabling the encounter, which Rogers (1980) calls "the basic encounter, the immediate relationship, from person to person" (p. 45).

The encounter group was a "point of departure" in that it enabled participants to live an experience which led to the expression of deep feelings in a short period of time. The interrelations established between the participants enabled one to look at one's self, to realise that despite sometimes feeling isolated an encounter can occur. It was also a "point of departure" to the extent that it enabled new ways of relating, through openness to experience.

Facilitator[7] intervention, both in the large group and in the small groups, was centred on the group and it was characterised by attitudes of congruence, listening with unconditional positive regard,

[7] Designation used by Rogers to refer to those members of the team who are responsible for managing group communication and the group process.

and empathic understanding. Thus, the facilitators concerned themselves with respecting the group's own process and with creating a safe and respectful environment in which each member could experience the wholeness of his or her being in relationship with the facilitator, with other group members, or even in silence. It is worth mentioning that some of the facilitators found it difficult to manage their dual role, simultaneously being a participant and a facilitator, and the degree of distance/presence/participation enabled and implied by facilitation.

After each session, the facilitators would come together to perform a comprehensive analysis of the group's movement, from the Person-Centred Approach perspective – a key moment for understanding, integrating, and clarifying experiences, enabling a progressive fine-tuning of the facilitators' empathic understanding.

Taking stock of this "Encounter Groups" workshop, we can define it as a space for communication, a space for learning to relate, as well as a space for motivating team members to engage in a theoretical reflection which is extremely important for improving skills for future interventions.

In short, we learn by doing and by experiencing the relationship, we learn about the relationship. We felt more enriched and learned by those few days, by that experience, more so than by any amount of reading or theoretical work carried out over the course of our experience and training.

Chapter X

Drug Addiction from a Holistic Person-Centred Perspective

Approaching the person from a global perspective inevitably means to take into consideration the person's background, to view the person from within the context and history of his or her life. Drug addiction is a complex issue, in no way less complex bearing in mind that it concerns humans, complex beings *par excellence*. It would undoubtedly be extremely gratifying to have quick, easy, straightforward solutions at hand, but the complex nature of this issue calls for a complex response. Thus, we will try to give an overview of the Person as a whole, by taking a look at how he or she develops.

Looking at a pine cone, it is hard to imagine that it contains the potential to become a magnificent pine tree. A pine tree can take on any number of forms, depending on the conditions, ideal or not, in which the pine cone germinates and develops. Thus, for instance, along the coast, in areas battered by northerly winds, pine trees are low, completely bare on one side, twisted, **the angle of their stems indicating the strength and direction of the winds to which they are exposed.** When they are grouped together, their crowns blend to form a more or less circular shape. But as we move into the pine forest, we will come across trees that already have a certain height, and further

in we will find trees that are as high as, or higher than, a person; that is, where there is protection from the bitter northerly winds, we will find mature pine trees, at the height of their development. The same plant, the same pine cone, can grow into a twisted, often miserable-looking tree in one place and, in another, develop into a fully thriving conifer.

The human being, like other living beings, is born with inherent potential, potential which, unfortunately, is not always greeted with the most desirable and necessary conditions for the person to be able to develop fully, through the actualisation of his or her skills and capacities.

Curiously, human beings exist well before they are born. Diachronically, chronologically and historically speaking, the period from the cradle to the grave can be thought of as a special space in time during which the humans maximise, or try to maximise, their potential. But even before this time, and certainly well after it, human presence exists, remains, *is*.

Preceding birth there is a kind of "tree", lost in the darkness of time, incorporating our parents, grandparents and ancestors. For the child about to be born, this "tree" bears the family's genetic heritage, a wealth of possibilities in terms of variety, making it possible, for instance, for the child to have the same eye colour as that of the grandfather whom the mother and father both liked, or the same hair as the alcoholic grandfather whom no one in the family liked. It is what enables us to be born healthy, but it can also be the reason why we

are born with a serious genetic disease or marked disability for life. Although we take the role of genetic inheritance into consideration, it not the only thing is important. Parents dream about and create expectations for their child well before the child is born. And this child, still in his or her childhood, will outline plans that will perpetuate over time, as children from a tender age have the ability to project themselves into the future, a future that transcends them.

However, there are many circumstances which are charged with a high degree of negative energy such as, for example, an unwanted child, one resulting from rape. Sometimes, a child born under extremely tragic circumstances is not seen by the family as a blessing, rather as a burden, a source of sadness, a tragedy or mishap which, unfortunately, has a negative impact on the child.

It is therefore extremely important that we be aware that a child is not born into our world as a "blank slate". He or she develops into a being over a long period of time, over space-time far exceeding the "gestation" period. He or she is a growing being, actualising the potential of his or her genetic load, as well as his or her affective, emotional and social loads, modulated by the circumstances of a pregnancy, which may or may not have been easy, particularly when there is suffering, illness or psychological stress.

When children are born, they experience a curious state of confusion between themselves and their mothers, on whom they are totally dependent, physically and emotionally. During a certain time, children are unaware of the boundaries between themselves and the

external world. Infants look at their fingers, put their fingers in their mouths, and in so doing they become aware of sensations in two different places: in the finger that is being bitten and in the mouth that is doing the biting. For a time, infants will use their mouths to explore the boundaries between themselves and the external world. With age, we lose the flexibility which enables infants to bite their toes, allowing them to distinguish between "me" and "not me", between "this is mine" and "this is not mine". However, when a child puts a toy into his or her mouth, he or she becomes aware of sensations only in the mouth, so there is something different about biting on a finger and "feeling" in two different places. At the same time, the infant lives in a curious world, one in which when he or she is hungry, he or she cries and then his or her mouth fills with milk, as if by magic; when he or she is wet, cries, and then ceases to be wet; when he or she is uncomfortable, because of something stuck to his or her bottom, cries, and the discomfort is removed. It is a strange and wonderful world, but what actually exists in that world?

At this stage of development, such a world could be conceptualised (careful however to avoid reification of the concept) as a world in which there is only one single relationship, the relationship the person has with his or her self. It is a world which can also be thought of as a system of subsystems, in which the two fundamental aspects are biological and psychological, aspects that begin to organise and emerge as the child explores the boundaries between "me" and "outside of me".

The child quickly becomes aware of the fact that his or her mouth does not always fill with milk whenever he or she is hungry and cries. The child experiences interruptions, that is, he or she experiences another important aspect of the world: the fragmentation of time, the rhythm of time. The child gradually becomes aware that another person exists beyond the boundaries of his or her world, and although these boundaries seem quite tenuous at first, they gradually become more defined, clearer, more concrete. The other person is the mother or whoever takes on that role. In the beginning, the child's world consisted of only one relationship, the relationship the child has with his or her self, and now we see a new type of relationship forming, an interpersonal, person-to-person relationship between the child and the mother. The world of the child, of the Person who is becoming, is progressively enriched by a new dimension.

This discovery of the mother as a singular Person seems to us to explain why children, from a certain age, stop smiling at those who approach them, even if it is just a round piece of cardboard with two holes cut out in it, and start crying whenever anyone other than the mother comes near them. Gradually, the other Person is recognised as an important being and, at the same time, a relationship, unrivalled in terms of its quality, is established – the relationship with the mother, a dyadic relationship.

As the child develops, he or she begins to realise that that special relationship with the other being, the mother, is "disturbed", because others are "competing" with him or her for the mother's

attention. These others can be the father, a sister or a brother, a neighbour, though usually it is the father or one of the child's siblings. The child's social world is enriched by a new relationship through a process of sharing with the group, a sharing that is not always easy. Sharing a toy or a dessert is not always easy, but sharing a mother's love and attention is even less so. Great sharing can take place, when toys are given or lent, but there are other occasions where the "need" for equity is so great that the number of peas on the other person plate are counted.

As already mentioned above, the child's world is enriched by this new dimension, the group, or stated another way, the child's world becomes a system made up of three subsystems: personal/individual, interpersonal and group.

The child grows, develops, actualising his or her potential during adolescence through contact with school, after which he or she will engage in a new type of relationship, one relating to the world of work and earning a salary, the relationship with an organisation, where work carried out is remunerated. It is another type of relationship, irreducible in terms of preceding relationships.

We all know about the patronising boss. Loved or hated by his employees, he is the parasite who exploits and perverts the relationship one has with the organisation.

This transition to the organisational dimension often occurs far too early in life, further helping to contaminate that relationship. How often have we not marvelled at an oriental rug without knowing that

the thinner the rug is the more knots it has per square centimetre, work that requires small fingers? Each of these wonderful, high-quality rugs means that a number of children have established a relationship with the world of work-salary, at a time when childhood relationships have not yet been sufficiently structured, actualised, providing children with protection and the means to develop.

Thus, we can say that the world of the person undergoing development, which, in our society, occurs between the ages of sixteen to eighteen and twenty-five to twenty-eight, is made up of four types of relationships or, systemically speaking, a system comprising four subsystems: personal/individual, interpersonal, group and organisational.

The person will continue to develop, to actualise his or her potential, and, gradually, he or she will form a new type of relationship, through contact with society's principal institutions, not only with the world of education, school, as already discussed, but also with military, legal and political institutions, among others. It is worth bearing in mind that each of these relationships is irreducible, although, as already stated, one type of relationship can be contaminated by the quality of another type of relationship. At the highest level of society, we are all familiar with the tendency of some male politicians to think of themselves as the "Father" of the nation or the people they govern. This tendency, this perversion of relationships, is a constant, and instances of this can be found in the history of nations, for instance, Salazar in Portugal and Stalin in the

former Soviet Union, both of whom thought of themselves as "the 'father' of the poor", their fellow citizens; in either case, this perversion levied a hefty price on society.

It is important to be aware that the nature of every new relationship is different to that of preceding relationships, and if there is any confusion or abuse within a relationship the situation can become problematic, as the actualisation of a person's potential can always be stunted.

Finally, we believe there is yet another type of relationship, one that develops as the person matures, a relationship we consider to be important. Curious by nature, human beings ask themselves: Who am I? What am I? Where did I come from? Where am I going? Who made me? Who made the world? These questions, which gradually surface over the course of life, are answered by the person in accordance with his or her stage of development, a strategy that applies to all humans. For example, when we show a child a narrow glass and a wide glass and pour water up to the same level in both, the child will, up to a certain age, say that both glasses have the same amount of water, because the level is the same for both. But at a later stage, when the child is more developed from a cognitive point of view, if we speak to the child about this experiment, then he or she will not hesitate to answer that it was the wide glass that held the most amount of water. In other words, how we reason and the way we reflect on things depends on the stage of our development. The same applies to sex education for children. That is, progressive parents may

explain to their child what really happens, and if we question the child about the issue, he or she will, initially, respond in accordance with what was taught by the parents, and later on he or she will remember that the parents told the truth. However, if, in a second moment, we want to know what the child thinks, we find that he or she will provide an explanation that is consistent with his or her age, regardless of the information he or she has been given. For example, for some children of a certain age a baby is inevitably the result of something that was swallowed by the mother.

We interpret the world in accordance with our psycho-affective and cognitive development. Thus, answers given by children to fundamental questions on the very meaning of life will vary, though the more traditional response (in our Judeo-Christian culture) will refer to the divine: "It was God who created the human race, it was His will, we are here because it is the will of God". Nevertheless, how often is this not a God "plagued" by our earliest relationships? Thus, God is a Father who is more or less good-natured, more or less benevolent, more or less fair, more or less strict, and the world is His creation, created in His image. However, progressively, a new type of relationship emanates, our relationship with the Absolute, with Transcendence, with a God who, in our capacity as an adult with the freedom to choose, no longer is created in the image and likeness of Humankind, or our father. A transition occurs, from a God who ceases to be anthropomorphic to a God transcending us, a God we are unable to conceptualise, and who many theologians consider indescribable.

From our perspective, as the person matures, a sixth type of relationship will develop, what we call the relationship with Transcendence. Freud, a self-professed atheist, who considered religion to be "humanity's neurosis", just as someone once said that religion was the "opium of the people", admitted to the existence of an "oceanic feeling", for the want of a better expression, in one of his conversations with the great French writer and philosopher, Romain Rolland. Like the anthropologist E. Sapir (1967), we can accept that "for a normal individual a *belief* in the *reality of molecules or atoms is of exactly the same nature as a belief in God or* immortality" (p. 195). What Freud (1963), in his letter of 20.07.1929 to Romain Rolland, referred to as "oceanic feeling" (p. 434), we prefer to call noetic experience.

Thus, a fully functioning Person can be seen as a world made up of six types of relationships or, stated another way, as a system integrating six subsystems: personal/individual, interpersonal, group, organisational, societal and noetic; more a six-dimensional world than a system.

How does all of this relate to drug addiction? Our aim here was to highlight the fact that there is a specialist for each type of relationship. Focusing on the biological aspect of the child at birth, we find that paediatricians have a special inclination for this being and that, as the child becomes more complex, those specialising in the field of biology tend to reduce the complexity of the child to a single

dimension. For instance, we now know that the brain of an addict does not function in the same way as that of a non-addict, regardless of whether the addict is abusing substances typical of the northern hemisphere, such as alcohol and tobacco, or the southern hemisphere, such as hashish and heroin. Brain research has highlighted the presence of anomalies, that is, P300 electroencephalographic anomalies, not only in the brains of those with an addiction but also in individuals who share the same gene pool. This fact has caught the attention of a large number of scientists worldwide who spend their time looking for a biophysical or bio-pharmacological solution to the problem of drug addiction. Thus when we bring up other dimensions inherent to the person, scientists tend to adopt a critical stance, labelling this as groundless reasoning, in other words, as something metaphysical.

But if we now turn to other specialists in the area of relationships, especially dyadic relationships, these specialists have found "good" relationships, for example, between an alcoholic and his or her bottle of alcohol, by drawing an analogy between the bottle of alcohol and a baby's bottle. There is extensive research available in this area, especially research focusing on the psychodynamics, psychoanalysis and psychotherapy of alcohol, and a large volume of work focused on drug addiction in general. Thus, those engaged in this domain, in this specialised area of expertise, tend to adopt a reductionist attitude, believing that the solution to the problem of drug addiction resides in the resolution of intrapsychic conflict through

psychotherapy, regardless of whether the psychotherapy is based on a psychoanalytic or person-centred approach.

Next, we move on to the specialists in group relations for whom the problem resides within the group, obviously. The first group we become a part of in our lives is that of the family – a group that undoubtedly has very specific qualities, but that nevertheless is a group. A large number of specialists have emerged in this area, both for groups in general and families in particular, who have a natural tendency to reduce the problem to an issue within the family; that is, in their view, addiction can be resolved by using a specific approach, a family therapy approach, modifying the addict's family system.

Other scholars are more interested in organisations, spending their time on issues concerning social injustice in the workplace, committing themselves, for example, to the causes of a trade union. They are convinced that the fight to overcome issues such as unemployment, the fight to create better, more satisfying conditions at work, will resolve the problems of organisations, which in turn will definitively resolve the problem of drug addiction, better yet, not just drug addiction but all other problems in society.

Then there are others, who "battle" in the political arena, the highest level of society. Here, the "battle" is towards a more just, more democratic society, one in which people's rights are respected and there is equal opportunity for all. Even knowing this to be impossible, that this is a utopia, the conviction is that utopia can only be reached if it is fought for, and if it has strong roots. Thus, those engaged in this

"battle" tend to reduce the issue to a single dimension, that of politics and governing bodies.

There are also those for whom life is solely a noetic experience. Persons committed to God, their faith, their spiritual realm, their vocation. They are filled with enthusiasm and fully convinced that God can resolve everything, which from our perspective is true, but it is also true that the way of God is not our own and we cannot simply "force" the hand of God. These persons tend to forget everything else in life, even if on occasion they do refer to other things, attempting to reduce the wealth of divine creation to a single dimension, turning Human Beings into disembodied souls, and the greater the level of disembodiment, the greater the level of perfection.

Humans beings are complex creatures and, as with all issues concerning human life, drug addiction is a complex problem, one that incorporates every aspect of the person's life, meaning that all aspects must be taken into consideration. The approach towards the problem of drug addiction or, better still, towards the problem of the real-life drug addict, who is a member of our family, who comes to us, who we know, must be a transdisciplinary approach, one that encompasses every aspect of the person's life. The person needs to be very careful with his or her life. His or her body, so often abused and affected by disease, specific diseases, must be treated, but there are times when the person who is suffering loses qualities inherent to his or her relationships. These qualities need to be restored, worked on and

enhanced. Thus, community groups and families must find more adaptive ways of functioning, ways that will enable them to actualise their potential. The person's relationship with the world of work must be improved, cared for, dealt with.

Finally, even institutional-societal aspects should not be overlooked. We must continue to strive for global solutions. The programmes developed by institutions dedicated to the prevention of drug abuse and recovery from drug addiction represent but a simple "drop in the ocean", but it is all that can be done at the present time. These efforts cannot be ignored, but studies aimed at rethinking society, its institutions and the way these operate, should also not be ignored.

To conclude, we would like to stress the highly dysfunctional nature of the relationship with Transcendence. A European specialist in drug addiction once stated that when drug addicts, especially those using hard drugs, inject themselves, in that moment when a "flash" occurs, they experience an intense and incomparable sense of pleasure. According to this specialist, having an orgasm is about the nearest one could get to this experience. In sum, the amount of pleasure society has to offer is always inferior in terms of its quality, though pleasure exists, and the relationship with the Absolute has disappeared; the drug, the psychopharmacological substance, has become another form of "absolute", one that disrupts the person's ability to harmonise with the Absolute. The problem, most of the time, for addicts is when the amount needed to reach the same level of

pleasure and satisfaction exceeds the amount their bodies are able to absorb; how often have we not been confronted with youths who want us to help them, to rehabilitate them, only so that they can once again experience that level of pleasure they no longer feel, and yet we can understand the human being from a holistic, whole, global perspective. We feel that the different areas of expertise should come together in a humble fashion for the sake of a common cause, a transdisciplinary effort wherein there is a place for biomedicine, psychotherapy, the family, the trade union, politics and the spiritual.

Chapter XI

The Centred Approach, Pedagogy, Power Relations and Ethics

In Ancient Greece, a pedagogue was a slave who was responsible for escorting a child to school. As civilisation evolved, the slave became a teacher and master, achieving the status of expert in the art, now more commonly known as: the educational sciences.

We find this change in status, from slave to master, to be highly significant; from being "at the service of the child" to becoming "master of the child". Power is knowledge that has been capitalised. Empowerment through knowledge is something which has occurred throughout the ages within what we call the "pedagogical relationship" (Freire, 1968/1974), viewed by some as an oppressive relationship, a means of gaining and retaining power by depriving others of their freedom.

It is worth remembering that in a relationship there is a subject who relates, an object who is being related to, and a purpose for the relationship between the two parties. In a relationship, the relating party is modified by the relationship and the relationship is modified by the relating party, but only if both parties involved are simultaneously modified by the relationship, meaning that both

parties are, simultaneously, the subject and the object in their relationship with one another.

Relationships can be established on principles of equality or inequality, symmetry or asymmetry or, sometimes, opposition or rejection. A symmetric relationship is one in which each of the parties involved is the subject of the relationship, in other words, both parties find themselves in a subject-to-subject relationship. The human capacity for establishing relationships is, without doubt, genetically determined, but its specificity resides in the need to relate so as to be able to exist as a Human Being.

There is, at the outset, an imbalance between the parties involved in a pedagogical relationship. A child, born as an incomplete being, who is being led (as in the original meaning of pedagogy), who is in the process of becoming, does not seem to carry as much weight as that of a leader, trainer, instructor, or depositor of knowledge to be conveyed. The proverb "spare the rod and spoil the child" implies the use of force when dealing with weakness in order to achieve 'admirable results', and then there is also the saying: "as the twig is bent, so is the tree inclined".

Indeed, the pedagogical relationship emerged from the Schools, frequently 'chapels', based on the trends, ideologies and 'scientific knowledge' of the time, as well as on personal attitudes towards the relationship – some placing greater emphasis on the so-called formative aspects of the relationship, others on the use of the relationship for transmitting content. It is clear, however, that there is

one constant: the pedagogical relationship is inherently asymmetric. This asymmetry may be more or less obvious, more obvious in the education of children, less so in the education of adults, though this does become clearer when one pays close attention to the nature of the relationship as its potential grows.

Based on his analysis of the characteristics of the traditional pedagogical relationship, which he calls "banking", Paulo Freire (1968/1974) highlights the extreme and caricature-like aspects of its asymmetry. Dialogue, which he regards as central to subject-to-subject relationships, to the educator-learner relationship, "vanishes within a narrating relationship" (p. 50), characteristic of anti-dialogical action, whereby the narrating subject (educator) stands before a listening object (learner), that is, a passive object *par excellence*.

Narration petrifies words, rendering them lifeless; the message being delivered becomes noise, possible meaning becomes obscured by meaning from a different discourse, one that aims to alienate, a discourse of power embedded in a relationship based on dominance.

The underlying premise is that the educator knows what the learner is ignorant about. The ignorance of one party is the *raison d'être* of the other, implying the notion of a profound sense of interdependence without which the 'relationship' cannot exist. Without the learner there is no educator; the existence of the object is vital for the existence of the subject. Paradoxically, the power of the subject (educator) depends on the existence of the object (learner).

The relational asymmetry of the "banking" method of education, to use the terminology of Paulo Freire, implies that people are treated as objects, and that there are clear rules regarding how the relationship should function.

In his assessment of the traditional pedagogical relationship, Freire criticises the oppressive relationship and proposes, as an alternative, a "pedagogy of the oppressed" by which the oppressed are able to liberate themselves, thereby (he believes) enabling the liberation of the oppressors.

Asymmetric relationships are inevitably manifestations of power. Our everyday comforts and technologies are driven by an actualisation of the potentials of asymmetry, thermodynamic, electromagnetic or otherwise. The power derived from relational asymmetry is a special case in the world of human relations, a feature that is typical of asymmetric relationships. The nature, legitimacy and development of such power nevertheless urges us to examine its ethical implications.

The pedagogical relationship is by no means the only type of relationship to be confronted by questions on the ethical use of power derived from the asymmetry of the relationship. The doctor-patient relationship, the psychotherapeutic relationship and, generally speaking, all helping relationships in any field which favour, as stated by Barahona Fernandes (1991), a "bio-psycho-social-cultural" view of human existence, all face the same problem. These questions have traditionally been addressed through the development of ethical

codes for each profession, which act as a protection barrier against any thaumaturgical or totalitarian inclinations. Barahona Fernandes, who introduced the notion of anthroposciences, put forward the concept of anthropoethics, stating that: "(...) if we dare to propose the use of the concept of 'anthropoethics', it is because we believe, in light of our experience of over half a century of assisting those in distress, that we must view human suffering from a global perspective (current, retrospective and prospective), one that addresses every level of being, biological, psychological and social" (p.7).

"The ethics of human issues – *anthropoethics* – is thus embedded in our perspective based on convergence (of the multiple disciplines in multidisciplinary interaction, using a naturalistic-humanistic approach) and linked to our model of personality, within which these disciplines centre on the study of the *human being* (the multiple 'anthroposciences')". And, specifically referring to the field of medicine, he reminded us that: "No longer is it enough to formalise legal and ethical rules, principles and standards governing our conduct. We must become aware of the need for greater reflection, from a social, historical and cultural perspective, on 'issues of conscience' that arise in every clinical case. Therein lies the interest in and need for Ethics: the philosophy of values. Medical care, in addition to its requirement to be based on science and proper techniques, must be valid from an ethical point of view, meaning that it must be 'right', justified, "legitimate" (pp. 6-7). In other words, it must be for the "good", and only for the good, of our patients. However, B. Fernandes

seems to have left a key issue hanging in mid air, the issue of who is to determine and how is it to be determined what the "good" of our patients is.

The aim of an ethics code is to offer protection (Whom does it protect? The client from the power detained by the professional or the professional from his illusions of "being a wizard"?) and this is exemplified by the ethics code of AvenirSocial (2010), the Swiss Association for Social Workers, which states that:

- [The social worker] does not abuse his or her professional relationships for private gain (Article 4, paragraph 4);
- (...) avoids abusing the power he or she has been entrusted with or misusing knowledge he or she has of a situation (Article 5, paragraph 3);
- (...) encourages his or her clients to become more independent and responsible (Article 4, paragraph 3);
- (...) refrains from any action that may harm the physical or psychological integrity of his or her client (Article 5, paragraph 5);
- (...) shares his or her professional wisdom and experience with other colleagues, and in so doing enhances the body of professional knowledge (Article 13, paragraph 1).

The same concern for protection can be found in the ethics code of the American Psychological Association (APA), the source of inspiration for a number of other psychological or psychotherapeutic

associations (including, for example, the European Association for Client-Centred Therapy and Carl Rogers' Person-Centred Approach).

"Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness" (Preamble to the "APA Ethical Principals of Psychologists and Code of Conduct – 2010").

"Psychologists undertake ongoing efforts to develop and maintain their competence" (Standard 2.03).

"Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner" (Standard 2.06a). "When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties" (Standard 2.06b).

"Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences" (Standard 7.01).

"Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees" (Standard 3.08).

"Psychologists do not engage in sexual harassment" (Standard 3.02).

"Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority" (Standard 7.07).

"Psychologists do not engage in sexual intimacies with current therapy clients/patients" (Standard 10.05).

"Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard" (Standard 10.06).

"Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies" (Standard 10.07).

"Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances" (Standard 10.08b).

Being aware of the implications of such power within the pedagogical relationship, we recognise the need for appropriate measures of control, for developing and implementing a code of ethics, to be adhered to by all.

It is not, however, our intention to explore this issue in further detail within the scope of the present work, but we would like to share with the reader our thoughts on a number of aspects inherent to the pedagogical relationship, and to the therapeutic relationship for that matter, which is a special type of helping relationship, an interpersonal learning relationship, as stated by Rogers (1978a), thereby bringing therapy closer to education.

In our mind, the pedagogical/therapeutic relationship has a number of specific features: it is an asymmetric relationship; there is a more or less pronounced absence of choice for one or both parties within the relationship; there is a more or less marked presence of constraints; there is asymmetry in terms of the level of commitment.

If relational asymmetry is a source of power, then how is that power used and how is it prevented from being misused, what guarantees do we have? We do not think it is necessary to dwell on examples which illustrate how such power is misused. Suffice it to say that the emphasis placed by the codes of ethics we have cited, on how

such power should not be used, is a clear indication of the "demons" to be exorcised[8].

The imbalance in the relationship also corresponds to an imbalance in the benefits, without, in most cases, these benefits being clarified or responsibility for them acknowledged. Being aware of the asymmetric nature of the relationship is an important step towards recognising power and the power relation that one is party to. This awareness should spur us to reflect on the implicit or explicit purposes for which this power should be used. Acknowledging the explicit aims and stating the implicit aims or mutual benefits are crucial ethical requirements.

There are a number of attitudes which can undoubtedly increase or decrease the degree of asymmetry, increase or decrease the level of personal power. Symmetric relationships are founded on the free will of the two parties involved, on the absence of constraints and on the level of commitment of both parties. These relationships evolve in a free manner, constantly shifting and never completely won over.

[8] That the sexualisation of a pedagogical relationship is unethical and should be condemned, seems to be consensual. The more or less subtle use of the pedagogical relationship as a means to indoctrinate or obtain support for future takeovers of power, whether political, moral or economic, seems to be widely publicised, yet rarely is it the object of reflection in terms of its ethics.

The higher the degree of inner freedom each party within the relationship has, the lower the risk the relationship has of becoming asymmetric, thereby reducing the likelihood of power being abused.

As already stated, Rogers (1978a) proposed a number of attitudes, conditions, or possible ways to facilitate an increased sense of inner freedom and learning: confrontation with a real problem; confidence in the human organism; acceptance; authenticity of the teacher; empathy; and the provision of resources. Rogers takes the view that "the human being is basically a trustworthy organism which has within him or herself vast resources for self-understanding, for altering the self-concept, basic attitudes, and his or her self-directed behaviour – and these resources can be tapped only if a definable climate of facilitative psychological attitudes can be provided" (Rogers, 1986a, p. 16). And he goes on to say: "(...) this premise has enormous political implications. Our educational system, our industrial and military organisations, and many other aspects of our culture, take the view that the nature of the individual is such that he or she cannot be trusted. He or she must be guided, instructed, rewarded, punished and controlled by those who are wiser or who enjoy a higher status" (Rogers, 1986a, pp. 17-18).

Based on his reflections, and just like Freire (1968/1974) who in *Pedagogy of the Oppressed* was looking for new methods for the process of learning to become a liberating experience, Rogers (1978a) explores a new way of learning, one in which the asymmetry of the relationship gradually disappears as both parties within the

relationship maximise their "personal power". He would come to call this experiential or significant learning.

Implicit in significant or experiential learning are the assumptions of: personal involvement (the person as a whole participates in the learning process); penetration (the process provokes change in behaviour and attitudes, and sometimes even in the personality of the educator); and self-evaluation (the essence is in the meaning).

Significant learning involves techniques and attitudes. Techniques, according to Rogers, are of secondary importance, to be developed as and when necessary, whereas attitudes are vital and universal. Thus, the coherence, commitment and conviction of the educator, which enable the student to experience self-direction and freedom, contribute to the student's success in the learning process.

Rogers (1978a) considered three key, inseparable attitudes, characteristic of both the therapeutic relationship and the experiential pedagogical relationship: empathic understanding, unconditional positive regard and congruence, attitudes which are described in detail in Chapters II and IV.

In order to illustrate the importance of living these attitudes rather than using them as techniques, we will cite a poem by Fernando Pessoa (1986): "The poet is a faker. Who is so good at his act / He even fakes the pain / Of pain he feels in fact." He then adds: "Those who read his words / Will feel in his writing / Not the pains he has / But just the ones they are missing" (p. 314). By "faking" acceptance of the

other person, the educator or therapist, possibly "despite him- or herself", is forming judgements in his or her own mind, drawing irrelevance into the relationship, rendering it ineffective, and ends up deceiving him- or herself. This contradiction, internalised by the educator or therapist, generates an internal state of incongruence, one that by no means eludes being felt and perceived by the Other.

The art of pedagogy, as the art of therapy, expresses itself through an increased state of congruence between the "being in itself" and "being for itself" perspectives of the socio-anthropological system, by creating a climate that is liberating, both for the educator/facilitator and the student/client.

One difficulty faced by pedagogues and therapists is the ability to empathically understand the Other, when that person has his or her own culture[9] and a "different language", who sometimes uses similar words but which have different meanings. Pedagogues and therapists must have a solid understanding of cultural variations among humans, especially when working with populations that come from different social and cultural backgrounds to their own.

On the basis of his pedagogical experience, Rogers (1978a) postulated that all human beings have an innate capacity for learning. This potential expresses itself in a more obvious manner as the student

[9] For example, when working with groups of emigrants or refugees, such as people from Timor, Cape Verde, those returning to Portugal from Africa or from other parts of the world, gypsies, all types of fringe populations, etc.

experiences higher levels of relevance and meaning in the learning, in the freedom to be. Rogers (1978a) demonstrated the importance of the educator-facilitator's personal qualities for creating a climate which enables the person or the group to maximise their potential through the learning process.

Although, seemly, bound by traditional, institutional learning guidelines, the educator by sharing his or her authority and power can empower the student, enabling him or her to become a Person and a Partner in the learning process.

As already mentioned, Rogers (1978a) said that: "It does not seem reasonable to impose freedom on anyone who does not desire it" (p. 137). He thus adopted an attitude which contradicts the ideology of enlightened vanguards.

In this respect, the learning process involves maximising the personal power of both the educator and the student. Sartre (2007) asked: "what good is freedom without commitment"; and our view is: "what is the use of power if it is not to be shared" (Hipólito, 1980, personal communication).

We feel that this power relationship cannot be ignored, it must be clarified, "exorcised", and its ethical implications recognised. It is vital that these implications be addressed in at least two ways: by assiduously developing a code of ethics and professional conduct, as has been done for other "anthropo-sciences", and by favouring "pedagogies" such as experiential learning that commit to reducing the degree of relational asymmetry, to deeply respecting both parties

within the relationship, to recognising each party as the subject of the person-to-person relationship, thereby enhancing the freedom and personal power of both parties involved in the relationship.

Chapter XII

Psychoaffective Development - Psychopathological Implications

The schema we have been developing, and that is the focus of this chapter, is the theory of human development from a Person-Centred Approach perspective, which also aims to contribute to an understanding of psychological disorders as manifestations of the human being in constant actualisation.

One of the key concepts underlying Person-Centred Approach theory, and certainly Rogers' theory of personality, is the Formative Tendency. In one of his last writings, Rogers used the terms "syntropy" (Szent-Gyoergyi, 1974) and "morphic tendency" (Whyte, 1974) to postulate the concept of "formative tendency", meaning "an ever-operating tendency toward increased order and interrelated complexity, evident at both the inorganic and the organic level" (Rogers, 1983, p. 45).

By 1979, Rogers had already given consideration to some aspects of this concept, admitting as a hypothesis the existence of a directional formative tendency in the universe, namely in the

formation of crystals, the organization of stellar space, and in the development of organic life. This process of complexification (see Figure 1) will have started when the universe was born[10], which according to the perspective taken by some astronomers can be explained by the Big Bang theory[11]. In their book, *Dieu et la science* (2004), the twins Igor and Grichka Bogdanov state that "10^{-43} seconds after the initial explosion[12] the universe would have reached the size of 10-33 (...)", and matter "would have been made up of primitive particles, distant ancestors of quarks (...), with as yet no variation between these primary particles which would have interacted in a similar manner in this state. The four fundamental interactions (gravitational, electromagnetic, strong and weak) are as yet indistinguishable, confounded by a single universal force" (pp. 37-38). Then, slowly over a period of thousands of years, several elements began to appear in the Universe, giving rise to a progressive grouping of simple particles into complex, increasingly diverse groups. In line with Rogers' (1983) thinking, this process of expansion[13] and evolution

[10] The birth of the universe, what we call "point zero" is referred to as the "Initial Singularity" by Guitton, I. Bogdanov, and G. Bogdanov (2004); and I. Bogdanov and G. Bogdanov (2010, p. 249).

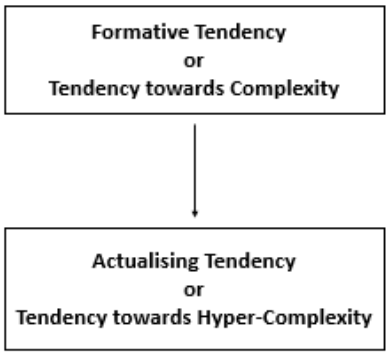
[11] The term *Big Bang* appears to have been coined by Sir Fred Hoyle in 1951 (Guitton, I. Bogdanov, & G. Bogdanov, 2004).

[12] 17.3 billion years ago (Guitton, I. Bogdanov, & G. Bogdanov, 2004).

[13] Some scientists believe that "dark energy" is responsible for the expansion and acceleration of the universe
(I. Bogdanov & B. Bodganov, 2004, p .256).

was due to the action of a Formative Tendency. In this continuum of transformation of matter, scientists believe that life began more or less 4.6 million years ago, though there is as yet no rational explanation for why this happened. From then on, the process of complexification will have accelerated, leading to reproductive activity, which in our view confirms the existence of a movement toward hyper-complexity.

Figure 1. Formative Tendency and Hyper-Complexity.



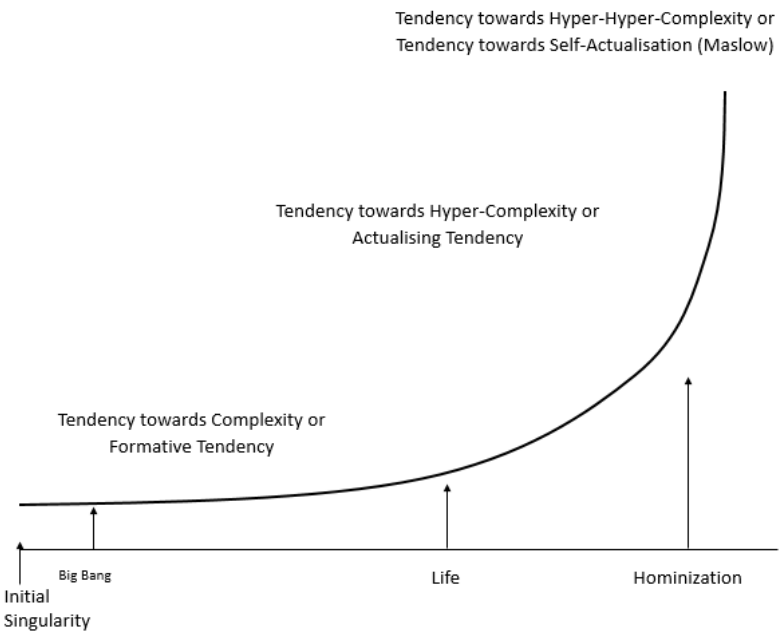
According to Rogers, when life emerges in the universe the *formative tendency* continues to manifest itself, albeit in a very specific manner which he calls the *actualising tendency*; this tendency is inherent in the process of growth and is, in Rogers' view, a non-specific capacity of the organism that, as a result of its own experience, enables the organism to fulfil its potential. Regarding the human species, Rogers emphasised that this tendency manifests itself as soon

as the human being starts to develop insofar as the functioning of a single cell triggers a process of complexification, enabling the organism to develop and progressively become a person.

Goldstein (1939), one of the pioneers of organismic theory, stated that "an organism is governed by a tendency to actualize, as much as possible, its individual capacities, its nature (...); this tendency to actualize itself is the basic drive, the only drive by which the life of the organism is determined (...). The tendency of normal life is activity and progress" (pp. 196-197).

In comparison with other living beings of the universe, human beings have very specific capabilities enabling them to accumulate, treat and transmit information in a very distinct and creative manner. A diachronic analysis shows us that there has been an evolutionary movement toward hyper-hyper-complexity or, as Maslow (1954, cited by Hall, Lindzey, Campbell, 1984) stated, a tendency toward self-actualization (see Figure 2). According to Maslow, there is a tendency toward self-actualization that expresses itself throughout the person's psychoaffective development: "healthy, normal and desirable development involves realizing one's nature, fulfilling one's potentialities, and developing to maturity along the lines dictated by one's own nature" (Maslow, 1954, cited by Hall, Lindzey, & Campbell, 1984, p. 49).

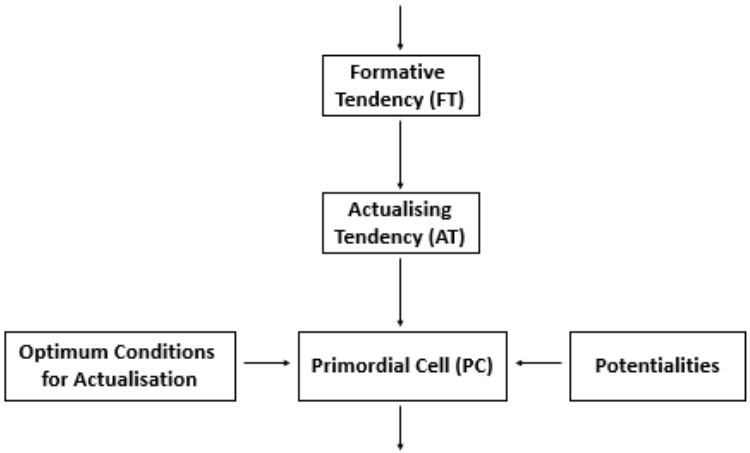
Figure 2. Illustration of the Accelerated Movement Toward Hyper-Hyper-Complexity.



This process, supported by suitable conditions, begins in the *primordial cell* (see Figure 3), the development of which is a manifestation of the actualising tendency. This cell or egg contains all information necessary for the maximum development of the potentialities of the living being, in genetically inherited data encoded with physical aspects (e.g., eye colour, height) and psychic capabilities.

These potentialities are an integral part of the primordial cell, but they may never come to fruition if optimum biological and psychological conditions, enabling the embryo to develop, are not created.

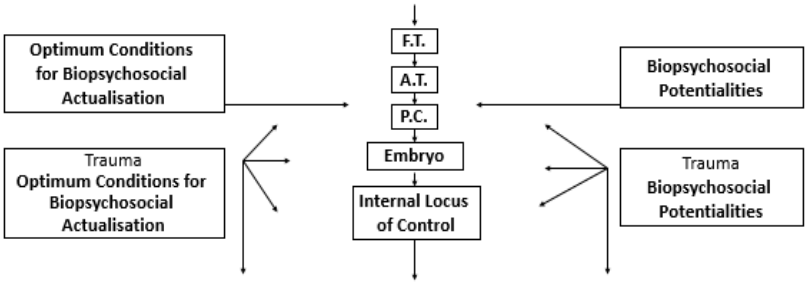
Figure 3. Primordial Cell: Potentialities and Actualisation.



The embryo under development is a vulnerable organism and subject to trauma, both in terms of its potentialities and the actualisation thereof which can result in the suboptimal expression of these potentialities. Trauma can have a number of causes, namely the mother may have a disease which affects the embryo, there may be a genetic problem, placental abruption may occur, or the mother may not be prepared to accept her unborn baby. Nonetheless, development proceeds autonomously, without any external regulation. The embryo is thus the only "manager" of its own

complexification until the time of birth. In this sense, it has an internal locus of control (see Figure 4) which is free from any interference from the external environment.

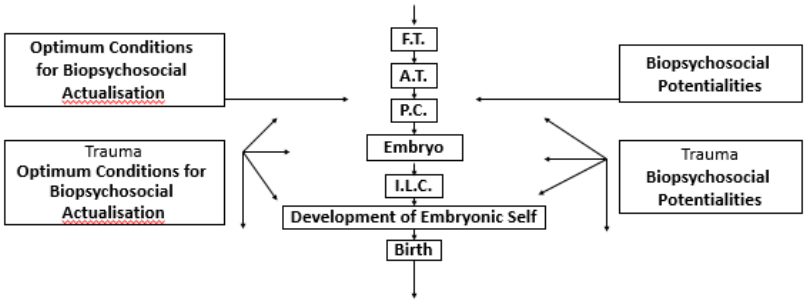
Figure 4. Embryonic Development, Trauma and Locus of Control.



The neurological system matures gradually during gestation (see Figure 5), enabling the development of the *embryonic self*, that is, various sensory experiences begin to merge in the self of the new being.

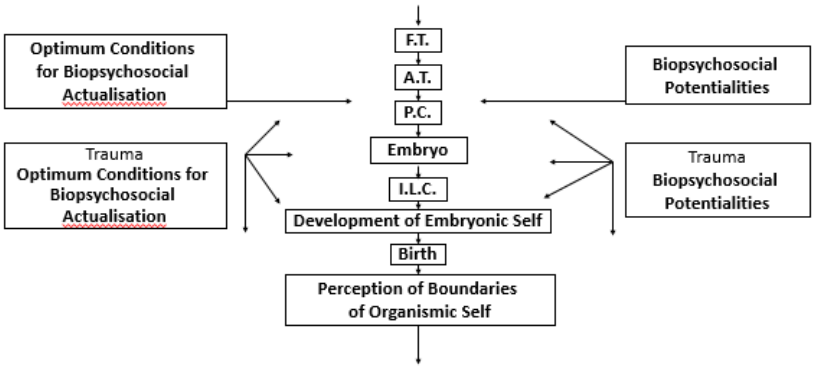
The fetus remains vulnerable to trauma that can affect its potentialities up to the moment of birth (e.g., anoxia, blood type incompatibility). In a similar vein, trauma can also act as a possible optimum condition for the actualisation of potentialities.

Figure 5. From Intrauterine to Extrauterine Life.



This process towards hyper-complexification continues when the baby is born, albeit in a less obvious manner. The development of psychological capacities along with physical growth give rise to a perception of the boundaries of the organismic self, meaning that the baby will progressively become aware of his or her "boundaries" in relation to the external world (see Figure 6). We are in the presence of the organismic self, in other words, a baby that symbolises the *totality* of his or her experiences: the baby does not feel sadness, he or she *is* sadness; the baby is every experience he or she has with the surrounding world. We can say that everything the baby experiences is fully integrated. As Rogers and Kinget (1971b) state: "he perceives his experience to be reality. His experience is his reality" (p. 19).

Figure 6. Boundaries of the Self.

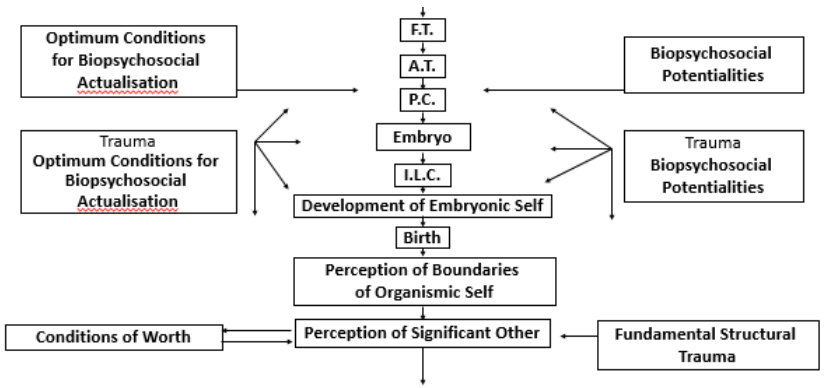


The perception of the boundaries of the self is accompanied by a perception of the significant other — the other is perceived as a complete and separate person, significant (mother) or non-significant (others). It is at this time (at the age of about 8 months) that the "conditions of worth" appear. If up until now the organismic feeling was all-encompassing, from the time of distinction between baby and other (mother), the baby's needs no longer become fully integrated due to a discrepancy between what the baby experiences as needs and the response from the mother. In this process, known as attachment, the baby becomes aware of his or her need for love from the other (mother), upon whom he or she depends and without whom he or she is unable to survive.

In his or her relationship with the mother, the baby comes to realise that there are specific perceptions regarding his or her needs and that these needs are not always well accepted by the mother (Brites, 2006). Thus, to retain the love of this extremely important

person, the baby learns to modulate his or her perceptions in accordance with the mother's "parameters" for acceptance, an acceptance that is conditionally positive, that is, one that depends on maintaining conditions of worth (see Figure 7).

Figure 7. Fundamental Structural Trauma.

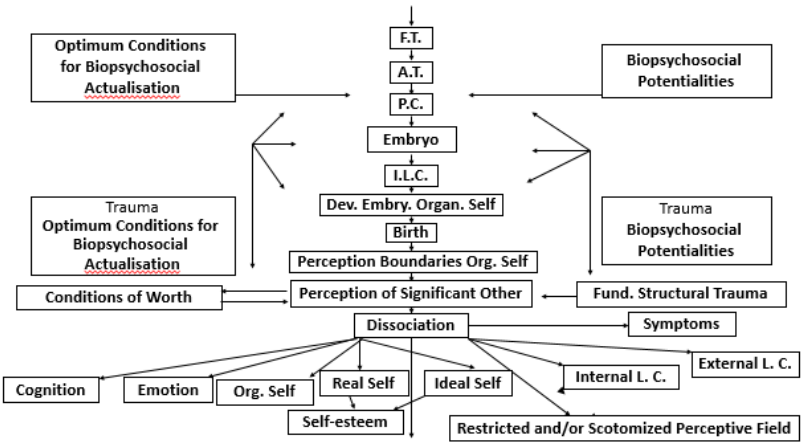


These conditions of worth trigger a dissociation within the baby, between what he or she feels (experiences) and what he or she will symbolise, in other words, that which will be integrated into his or her field of perception. For example, if what the baby is feeling contradicts the mother's conditions of worth, then the baby will symbolise a different experience in his or her field of awareness, one which is consistent with the mother's conditions of worth. This leads to the formation of a restricted and/or scotomized field of perception, meaning there are perceptions that cannot be symbolised and are denied into awareness (the child is unaware that he or she has such

sensations), or perceptions are distorted so that they become acceptable.

This dissociation (see Figure 8) gives rise to a series of dissociative processes in the child which manifest themselves at various levels of experience: between the internal locus of control (how the child experiences phenomena within his or her self, how he or she feels them) and the external locus of control (decisions made by the other, even those which relate to the child); between the organismic self, real self or, to be more precise, perceived self (how the child perceives or experiences his or her self) and the ideal self, also known as the desired self (how the child needs to be in order to be accepted by the other); between cognition and emotion (two aspects of an experience that are no longer integrated in the same perception of the experience).

Figure 8. Dissociation and Symptoms.

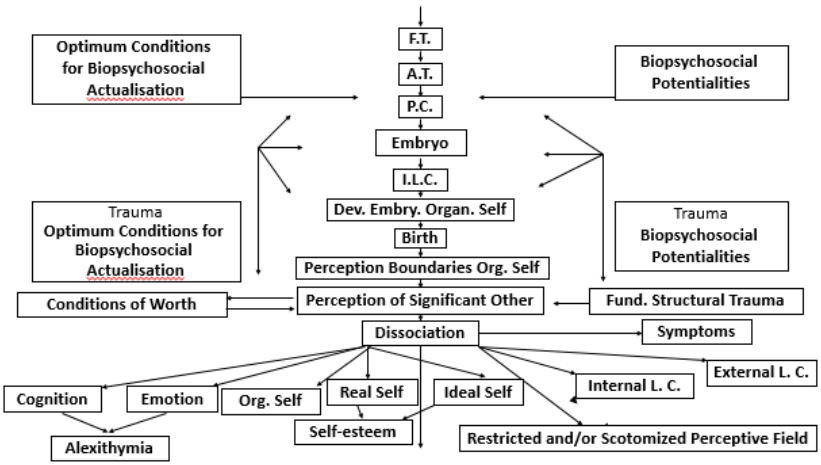


Whenever dissociation occurs, tension is generated between the two "poles" involved. If the organism is unable to balance this tension by itself then symptoms will develop. A symptom reflects the organism's best possible state of equilibrium and is considered to be positive insofar as it was the way in which the organism is able to organise itself in a given situation so as to continue functioning.

Dissociation thus manifests itself in the various realms of the child's life. In the case of the self, the higher the level of dissociation between the perceived self (how the child feels he or she is) and the desired self (how the child feels he or she should be), the lower the level of self-esteem. When dissociation involves cognition and emotion (see Figure 9) one possible symptom is alexithymia, both at the level of perception (the person is unable to recognise his or her

emotions and feelings) and expression (the person recognises his or her emotions and feelings, but is unable to describe them).

Figure 9. Symptoms and Field of Perception.

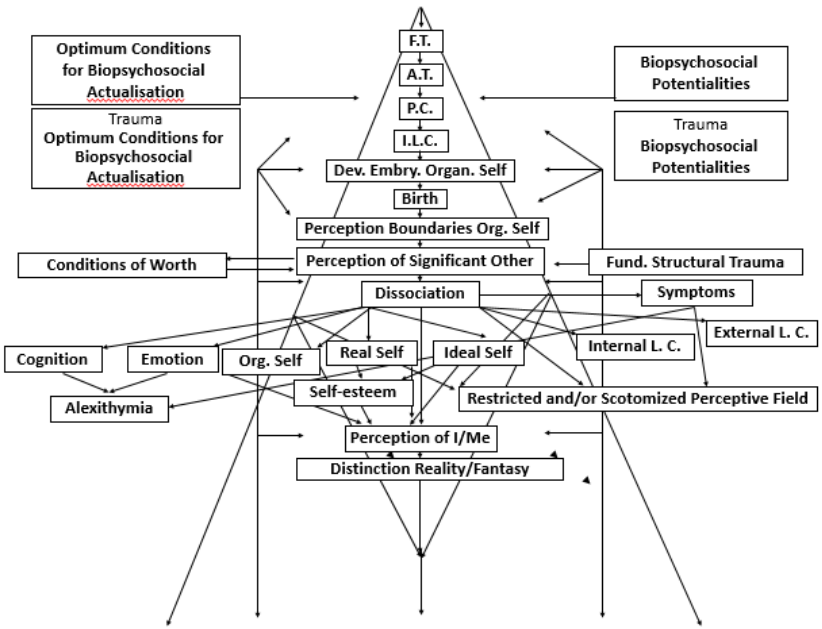


The child continues to develop and at about 18 months of age, he or she has a distinct perception of "I" and "me" (until this time the child refers to him- or herself as "baby", "Bobbie" or "Maggie"). Between four and eight years of age, the child learns to distinguish between reality and fantasy[14] (see Figure 10). Prior to this stage, children are unable to tell the difference between what is real or

[14] In this instance, it would not be appropriate to talk about schizophrenia, hallucinations or delirium, as described in the World Health Organization's ICD 10 - International Classification of Diseases, because, before the age of about 8 years, children are unable to distinguish between reality and fantasy.

imaginary, which is something that can be observed when children talk about an "imaginary friend" or when they tell "lies".

Figure 10. From the Perception of *I* to the Distinction between Reality and Fantasy.

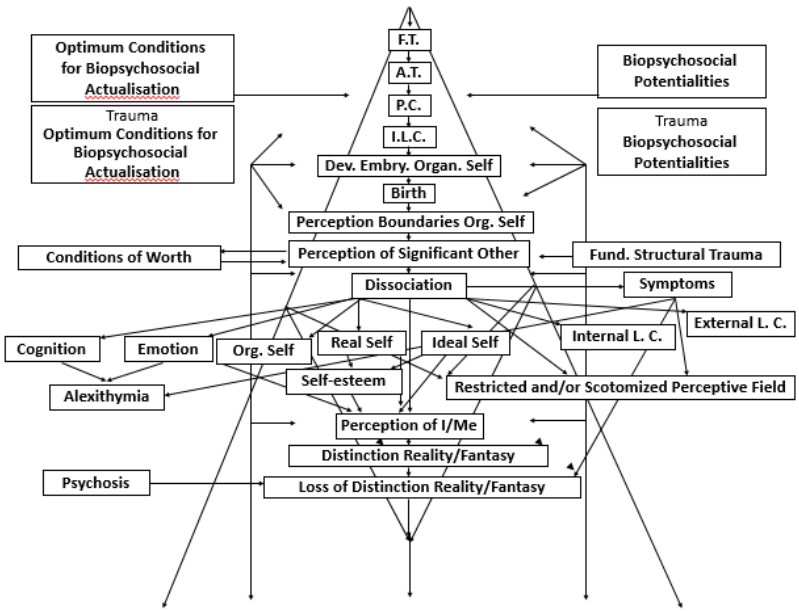


If the child grows and develops in a natural and healthy way, supported by the best biological, psychological and social conditions for optimum actualisation and minimum conditions of worth, in other words, with maximum unconditional care and without his or her being as a person being undermined, then the child will fully actualise his or her potential.

However, traumatic events are a constant threat at various levels of being (biological, psychological, social) throughout life, subsequently giving rise to trauma and symptoms during our existential journey.

Symptoms might not affect our ability to distinguish between reality and fantasy, they might manifest themselves at the physical (somatic symptoms) or psychological (neurotic symptoms) level. Nevertheless, in both cases we believe that the objective is the same, namely to maintain the organism as fully functioning as possible. Indeed, symptoms can affect our ability to distinguish between reality and fantasy, but the purpose remains the same: to maintain the organism as fully functioning as possible. When this happens, symptoms triggered by trauma are of a psychotic nature (see Figure 11), just as when symptoms appear at an early stage of development, hindering this ability to differentiate.

Figure 11. Loss of Discrimination and Psychosis.

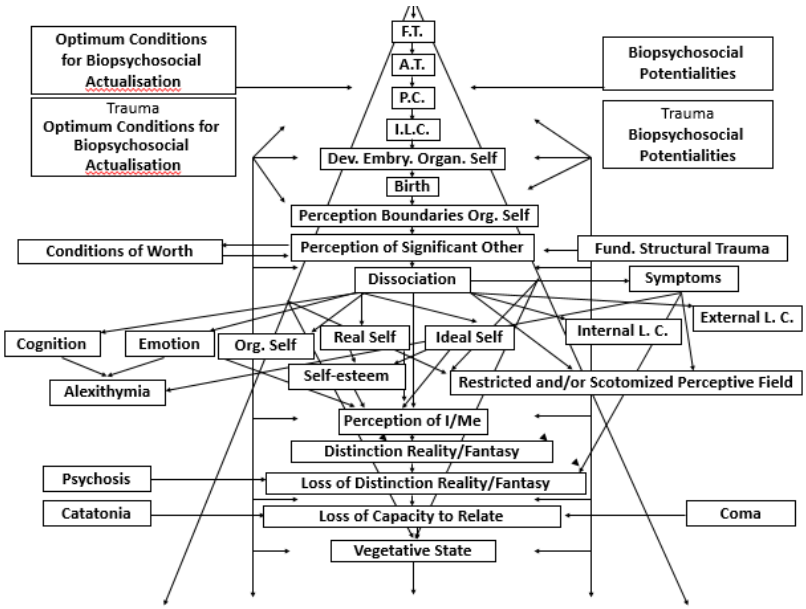


If the loss of the ability to distinguish between reality and fantasy becomes severe, there may well be an incapacity to relate to others (see Figure 12), which could manifest itself either in a physical way, such as through coma[15], or in a psychological manner, through the absence of psychological contact, as in the case of autism or catatonia. In the most extreme cases, the best possible way to continue functioning is in a vegetative state, in which there is no

[15] Coma is a manifestation of the *actualising tendency* to the extent that the organism reduces its activity to a minimum, enabling it to continue functioning.

apparent psychological life and where biology initiates a process of degeneration or sometimes, at best, of self-regeneration.

Figure 12. Loss of Capacity to Relate.



Our view is that psychopathology can be understood by articulating trauma over the lifespan, in terms of the person's potentials and the actualisation of these, based on the premise that self-healing forces are activated, which in themselves are manifestations of the person's ever-operating tendency toward hyper-complexification.

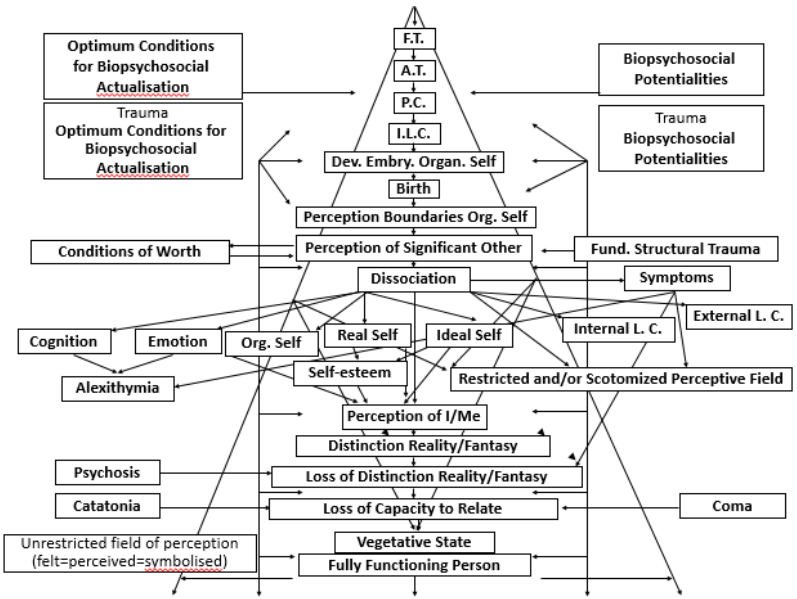
Considering that symptoms are the result of the organism's best possible state of equilibrium at any given moment, extreme caution must be exercised when it comes to the desire to eliminate

these before the organism has found an alternative and better state of equilibrium. Symptoms tend to disappear when they are no longer of any use for overcoming the conflicts that triggered them, or as a result of the natural processes of maturation and self-healing.

When developing a therapeutic project with the client, the "diagnostic system" must be taken into account. This is a feature of Client-Centred Therapy, based on the so-called "six necessary and sufficient conditions", and includes overcoming possible deficits stemming from trauma which require special measures (e.g., modifying eating habits, prostheses, special education, careful use of medication, including psychopharmacological medication, surgery).

Ideally, if full development without restrictions and with maximum actualisation of potentialities were possible, then we would be in the presence of a fully functioning person with an unrestricted field of perception, where the organismic self would be identical to the real self and ideal self, full and integrated functioning. If this were the case, and if life were without trauma or symptoms, then each person would live more fully, for as long as is theoretically possible for the human organism to function (see Figure 13). But, as ideal as these conditions would be, inevitably one day human finitude, destined even at the very heart of life through cellular apoptosis, would also actualise in death.

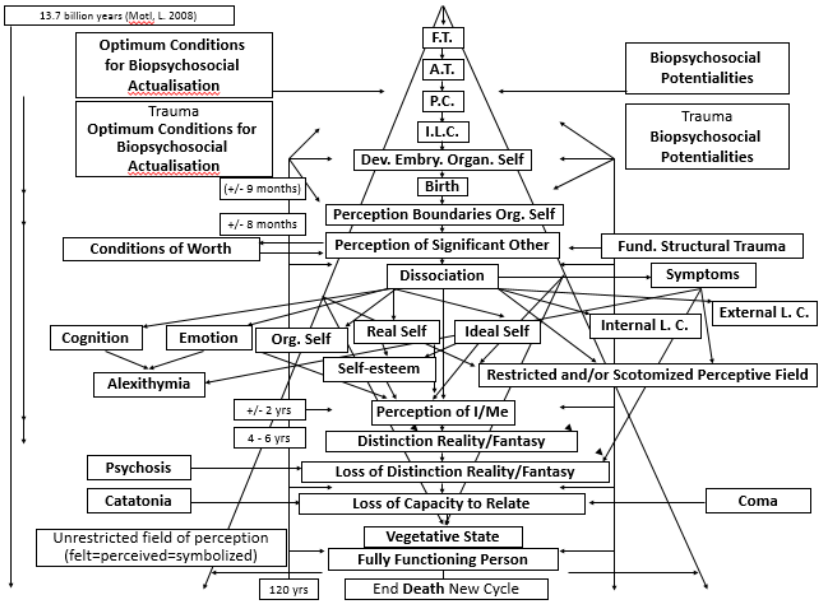
Figure 13. The Fully Functioning Person.



Thus, death signals the end of this process. We nevertheless ask the question: bearing in mind the Actualising Tendency of Humans, how can death be explained in the process of complexification?

If rather than looking at life from an individual perspective, or in terms of a generation, we look at life as the evolution of Humanity, then death marks the beginning of a new cycle (see Figure 14). Taking the rose plant as an example of another living being, and creating an analogy between its life cycle and the cycle of human life: every rose is the result of the flowering process of a rosebud. The rose gradually blossoms; once it is in bloom, showing its full splendour, its petals slowly begin to fall; the rose begins to wither and wrinkle ... Finally, the seeds of the rose fall to the ground enabling new rose plants to sprout.

Figure 14. Death and Cycle of Life.



The human life cycle also entails birth and death, which in turn gives rise to a new birth, although confronting the processes of aging and death can often be very distressing for the human being, especially when trying to understand the meaning of death in the meaning of life.

Given its transcendent nature, this is an area for which human beings frequently seek answers in the domain of noetics or religion. We finish up with the following question for further reflection: what would be the meaning of evolution if no human being were ever to die?

Chapter XIII

New Visions of Schizophrenia: Psychotherapeutic Advances

There can be no doubt that the introduction of chlorpromazine in 1957, and especially of haloperidol in 1959, laid the basis for a drastic reduction in the number of psychiatric beds around the globe. For example, the Júlio de Matos Hospital in Lisbon, planned for 800 beds in 1911, had 1200 in 1952 and currently has approximately 478 beds. The Malevoz Hospital in Switzerland, involved in a training exchange programme with the Júlio de Matos Hospital when the latter institution opened, had 450 beds in 1970, a number which dropped to 120 by the time the hospital celebrated its centenary in 1999.

One may however be left with the impression that until then, the treatment of psychoses, and of schizophrenia in particular, was limited to patient custody, following the "*Grand Renfermement*" (The Great Internment), a movement publicly denounced by Michel Foucault in 1961 (Foucault, 1961/2005).

Some attempts at applying effective treatments, especially biological, physical or even surgical, had already been carried out. In 1917, Julius Wagner-Jauregg introduced malaria therapy for the

treatment of neurosyphilis, a feat which earned him a Nobel Prize 10 years later. The success of this treatment led to its being used in the treatment of psychotic disorders.

In 1922, the Swiss physician Jakob Klaesi proposed so-called "sleep treatment" in combination with a psychotherapeutic approach strongly influenced by psychoanalysis. In 1927, Manfred J. Sakel introduced insulin shock therapy, or 'Sakel´s cure', consisting of an insulin-induced coma, combined with a powerful psychotherapeutic atmosphere, applied for many years with relative success.

The erroneous belief in the incompatibility between epilepsy and schizophrenia motivated research and development of artificial methods of inducing convulsions. It was on this basis that Ladislas von Meduna introduced convulsive therapy through metrazol injections in 1934, and, in 1937, Ugo Cerletti and Lucio Bini introduced electroconvulsive therapy. While metrazol-induced seizures have disappeared from the therapeutic armamentarium, the same does not apply to electroconvulsive therapy (ECT). Today, ECT is used in a number of specific situations and is especially efficacious in the treatment of psychotic depression.

As is common knowledge, Egas Moniz introduced prefrontal lobotomy in 1935, being awarded the Nobel Prize in 1949 for his contribution to the study of brain functions and the "treatment" of schizophrenia.

Nevertheless, and since the time of Philippe Pinel, the use of more psychological approaches to treating psychotic disorders was never completely abandoned.

Bockoven (1972, cited by Karon, 2003) claims that long before antipsychotics were introduced, and since the time of Pinel, "moral therapy" produced excellent outcomes, enabling 60-80% of patients to be discharged. When moral therapy was abandoned from the mid 19th century onwards, the patient-discharge rate dropped to 20-30%.

Moral therapy was based on four cornerstones: 1) the non-use of physical force or humiliation, with physical force to be used exclusively to protect the patient from him- or herself or to prevent harm being inflicted on others, but never as punishment; 2) recording as detailed a clinical history as possible; 3) encouraging work and social relations; and 4) bringing together all the efforts and commitment of the caregivers in such a way as to understand the patient as a human being.

The development of Freud's psychoanalytical model marked the psychological treatment approach to psychoses with an effort towards clinical investigation, though the focus remained primarily on the formulation of theory based on clinical case studies, the most famous of which is the case of Judge Schreber (Freud, 1911/1958). Freud was subsequently criticised for his elaborate interpretations of someone he never met, and for ignoring the role Schreber´s highly

unusual and traumatic past might have played in his illness (Storr, 1989).

Racamier (1974), one of the psychoanalysts most committed to the treatment of psychoses, published an article in which he presented an excellent review of the psychoanalytic approach to psychoses, an article which, despite its date, continues to be relevant within this field.

To illustrate this point we would like to refer the reader to Rosen's (1953/1960) work on the development of specific psychotherapeutic tools. Sechehaye´s (1954) psychoanalytical work also serves as a good introduction to understanding this problem. Finally, reading the description of a case study with a favourable outcome, such as the case study described relatively recently by Dorman (1999), may be extremely helpful.

Apart from psychoanalysis, other schools have shown interest in researching this area. This is notably the case of the Person-Centred Approach, extensively documented in the work of Carl Rogers and his colleagues. Within the Person-Centred context, we consider it salient to refer to a book published by Virginia Axline (1964/1988), on the therapy and case study of a purportedly psychotic child, and which remains a best seller in the field today.

With the introduction of antipsychotics, the importance of psychotherapy began to wane in favour of the greater and faster

efficacy offered by medication. However, a clear comparison between the two treatment approaches has never really been carried out. The disadvantages mentioned relative to psychotherapy are largely due to the great difficulty in developing therapist competence which requires a high level of personal and professional investment. Both therapist training and therapy itself are long and time-consuming processes.

A study carried out by Bockoven and Solomon (1975) compares the progress of two groups over the span of 5 years. Subjects in both groups were chosen randomly. One group consisted of 100 in-patients of a community-oriented psychiatric hospital in 1947. The other group was made up of 100 patients admitted to a community-based mental health centre in 1967, after the introduction of antipsychotic medication for the treatment of schizophrenia.

Although the first group did not receive antipsychotics, the results for both groups were similar, leading the authors to conclude that, perhaps, antipsychotics are not indispensable in the treatment of schizophrenia. However, no mention was made of the quality of life of the patients in the two groups, and the study was conducted prior to the availability of atypical antipsychotics, the first of which, clozapine, was introduced in 1970, followed by the so-called second-generation atypical antipsychotics: risperidone in 1994, olanzapine in 1996, quetiapine in 1997, and ziprasidone in 2000.

However, the long-term benefits of psychopharmacology over psychotherapy are far from consensual.

According to Karon's (2003) study on the long-term evolution of schizophrenia, the review carried out by Harding, Zubin and Strauss (1987) of five studies published by various researchers showed that in the long term, 30% of patients recovered completely and 60-70% became self-sufficient, without a clear role of the introduction of antipsychotics being evident in these findings.

Karon also states that the results of the Michigan State Psychotherapy Project, which involved the comparison between a group of patients whose treatment consisted of 70 individual psychoanalytic psychotherapy sessions, a group of patients treated with medication and a third group that received both types of treatment, showed that the third group had better outcomes than the medication-only group, but not better than the psychotherapy-only group, nor than patients who received medication for a short period which was then withdrawn (Karon & VandenBos, 1981).

Likewise, based on his experience, Lambert (1986) had already mentioned that using the lowest possible dosage of antipsychotics was one of the essential conditions for a psychoanalytical cure.

Currently, a much propounded idea is that it is bad practice to not prescribe an adequate dosage of antipsychotics in the early stages of the schizophrenic disorder, and experience shows that the mid- to long-term evolution of the disorder will be better the earlier that treatment is initiated.

Mosher re-examined the Soteria Project and focused on new admissions. He compared the results obtained by therapeutic communities, whose practice was based on no or only minimal antipsychotic medication, with the results obtained at traditional psychiatric hospitals, and found that after a 2-year follow-up, the subjects treated in the therapeutic communities showed better results (Mosher, 1999; Bola & Mosher, 2003). These results had previously been confirmed by the work of Luc Ciompi and his team, at the University of Bern, during the development of the Soteria Project Bern (Ciompi et al., 1993).

Ciompi claimed that "in a therapeutic setting and style of care especially focused on anxiety reduction, emotional relaxation, interpersonal support, and protection from affective-cognitive overstimulation, psychotic symptoms can disappear within weeks, with no or only minimal neuroleptic medication" (Ciompi, 1997, p. 167).

Thus, there appears to be sufficient evidence to support the claim that the absence of psychotherapy in the treatment of psychosis is bad clinical practice.

Ever since Engel (1977) introduced the concept of the bio-psycho-social approach (the Portuguese psychiatrist Barahona Fernandes has since referred to a bio-psycho-socio-anthropological approach), the notion of combining medication-based treatment with different socio-therapeutic approaches, offering the patient and his or

her family psycho-educational as well as so-called contextual and systemic therapies, has become widespread. However, psychotherapeutic approaches have regained some importance, most especially cognitive-behavioural therapy (Haddock & Lewis, 2005; Tarrier et al., 2004; Valmaggia et al., 2005), with its focus on symptoms, as well as the analytically based therapies. An in-depth review of these modalities is however beyond the scope of this chapter.

The biomedical model has come to dominate most treatment approaches, whether psychopharmacological or psychotherapeutic, implying a previous diagnosis of an aetiological nature, followed by, in the majority of cases, specific intervention based on the chosen theoretical model.

We consider it important at this point to mention another form of psychotherapeutic intervention, namely that developed by Carl Rogers, based on a holistic perspective, and known as the Person-Centred Approach.

Rogers postulated the existence of a tendency towards complexification, present at all levels of the universe, which he called the Formative Tendency (Rogers, 1978b). Where life occurs, this tendency accelerates, and Rogers called it the Actualising Tendency (Rogers, 1980). This tendency towards complexification or "hypercomplexification" has two corollaries. First, it takes into account the existence within the universe, from the inanimate level up to the

level of social organisms, of a drive towards self-organisation. Second, it considers the tendency of a given organism towards self-healing, provided the necessary and sufficient conditions are present. This trust in the self-organising and self-healing capacities of living organisms led Rogers to develop a conceptualisation of what he called the Non-Directive Attitude, the name by which his therapeutic approach was initially known.

Towards the end of the 50s and the beginning of the 60s, Rogers carried out research work at the university of Wisconsin that came to be known as the Wisconsin Project, and which he later described in the book *The Therapeutic Relationship and its Impact* (Rogers, Gendlin, Kiesler, & Truax, 1967).

Carl Rogers and his team tested various hypotheses related to the three basic attitudes of the therapeutic relationship, namely congruence, unconditional positive regard and empathic understanding. They developed a study that compared the evolution in psychotherapy of a group of patients diagnosed as suffering from chronic schizophrenia, a group diagnosed as having acute schizophrenia, a group with neuroses, a group of so-called normal people and a control group.

Of the various hypotheses of the study, the second claimed that “the same variables of process movement will characterize the in-therapy behavior of more acute schizophrenics, more chronic schizophrenics, normals, and neurotics” (Gendlin & Rogers, 1967, p.

17). “In so far as we were able to test this hypothesis”, writes Rogers, “the evidence was generally confirmatory. The major change which emerged from our findings is that the schizophrenic initially focuses more on relationship formation than on self-exploration, and thus some of the most characteristic elements of process for the neurotic are not initially present for the schizophrenic. Indeed, such self-exploratory behavior may never occupy as prominent a position in the therapy of the schizophrenic as it does in the therapy of the neurotic.” (Rogers, 1967a, p. 90).

Rogers stated that the therapists found themselves confronted with an unexpected difficulty: “they were new to the task of relating to individuals who had not requested help (...) [The therapists] were less expressive, less skilled in initiating a significant relationship than they later became (…) we failed to communicate to the normal subjects the possibilities which we had hoped they would discover in an expressive relationship (….) [the therapists] were faced with many difficult problems in establishing a relationship with the hospitalized schizophrenics and likewise with the normals, both of the groups being composed of individuals who were not seeking help” (Rogers, 1967b, p. 67).

Gendlin, a collaborator of Rogers on the Wisconsin project and founder of focusing-oriented experiential therapy, commented that “the initiation of psychotherapy is extremely difficult with discouraged, frightened, withdrawn, suspicious patients. Such patients

need to see and hear therapeutic relating with other patients and to approach and withdraw from it repeatedly before they can bear to try out such a relationship themselves" (Gendlin, 1967a, p. 526).

Based on his research, Carl Rogers (1957) proposed six necessary and sufficient conditions for therapeutic change to occur. These are: 1) that two persons are in psychological contact; 2) that the first, who is called the client, is in a state of incongruence, being vulnerable or anxious; 3) that the second, who is called the therapist, is congruent or integrated in the relationship; 4) that the therapist experiences unconditional positive regard for the client; 5) that the therapist experiences an empathic understanding of the client's internal frame of reference and communicates this to the client; and 6) that the communication to the client of the therapist's unconditional positive regard and empathic understanding is minimally achieved.

Rogers claimed that if these 6 conditions were present, then constructive change would occur in the client; if one or more were absent, then change would not occur. Furthermore, the dimension of the positive change would be proportional to the degree to which the six conditions were present.

Seen from this holistic perspective, psychological diagnosis, though highly important for research and communication within the scientific community, ceases to be important in determining the indications for psychotherapy. This is instead substituted by a new

"diagnostic apparatus" (Hipólito, 1992) which is based on the presence or absence of these six necessary and sufficient conditions for therapeutic change. The actualisation of the capacity for self–healing, and the attitude of trust in the organism's capacity for self-organisation, stem directly from these six conditions.

We see that with many patients (whom the Rogerian community prefers to call clients [Caldeira, 1979]), even those diagnosed with schizophrenia, the six conditions are present and it is therefore not necessary for the therapist to adopt a specific attitude, although, perhaps, greater importance is placed on the therapist's training and his or her therapeutic experience.

Inspired by the anthropo-analytical model, Caldeira claimed to define the operation of client-based practice, and complete it with original theoretical reflection. He thus contributed in a significant way towards practice and research in the field of the psychotherapy of schizophrenia (Dias & Caldeira, 1982).

In this paper it is our intention to concentrate on one of the more specific and frequent difficulties encountered with schizophrenic patients, namely the absence of psychological contact, the first of the aforementioned conditions.

Carl Rogers did not develop the notion of psychological contact as clearly and completely as he did for the so-called three basic attitudes of the therapist, which we have already mentioned. Rogers

said that psychological contact meant the presence of the essential minimum of the relationship, namely that each person made a perceived (or subceived) difference in the experiential field of the other. This presence could be minimal and may not be immediately apparent to an observer (Rogers & Truax, 1967).

Gendlin considered some of the difficulties encountered when trying to establish contact with some of the participants in the Wisconsin Project. He described some of the attitudes he assumed in order to develop contact, such as “touching [but in] a mode that won’t be confusing, sexual-like or frightening” (Gendlin, 1967b, p. 384). As an example he describes how, at a given moment, the therapist, at the patient’s request, offered him a cigarette although later he refused that same request; on another occasion he lent the patient money without asking why, but later he made demands concerning a new loan (Gendlin, 1967b).

Garry Prouty (1990) carried out an in-depth and interesting analysis of the Wisconsin Project, re-examining its results. Citing Tsakanika (1987), Prouty pointed out that “the severely disturbed individuals have difficulty perceiving empathic understanding and unconditional positive regard intended from the therapist. Empathic contact is thus not established and the therapeutic process is hindered” (Prouty, 1990, p. 646).

Prouty also stressed that Rogers had already spoken of the tendency of schizophrenics to relate "either by an almost complete

silence, (...) or by a flood of over-talk which is equally effective in preventing a real encounter" (Rogers, 1968, p. 185), and introduced the need for a "'pre' relationship or 'pre' experiential method" (Prouty, 1990, p. 647).

In his article, and following on from Peters (1986) and Merleau-Ponty (1962), Prouty (1990) developed the idea of psychological contact by defining it as a set of therapeutic techniques (contact reflections), of psychological functions necessary for therapy to occur and of emerging and measurable outcome behaviours.

Regarding schizophrenic patients, Prouty stated that reality contact is impaired which prevents the client from sharing "a mutual 'here and now' with the therapist"; and "communicative contact" is impaired, preventing the client from being "verbally expressive" (Prouty, 1990, p. 647).

Seen from this point of view, reality contact (with the world), communicative contact (with another) and affective contact (with the self) "are 'pre' conditions for therapy that must be rendered functional" (Prouty, 1990, p. 647), and consequently it is the psychological contact that permits the essential opening up to the world, the self, and to others.

Whenever this contact is absent in psychotic patients, Prouty proposed that it be developed through an approach he called "Pre-Therapy" (Prouty, 1994/2001; Prouty, 2003). This is based on a theory

and methodology of intervention which enables psychological contact, necessary for therapy, to be restored.

Prouty classified the five therapeutic techniques used, which he called contact reflections, as follows:

1. Situational reflections, facilitating the restoration and development of contact with reality, permitting the patient to enter into the context of his immediate reality:

2. Facial reflections, developing and restoring affective contact by means of making explicit the affect implicit in the client's face;
3. Verbal or word-for-word reflections, developing and restoring communicative contact by making use of the client's own verbal output;
4. Body reflections, developing a generalisation of contact in the "here and now", through the body-felt sense and in the reformulation of more or less bizarre movements and postures;
5. Reiterative reflections, developing contact through the repetition of reformulations that proved effective before.

With regard to these contact functions, reality contact (with the world) means that the person is aware of others, things, places and events; affective contact (with the self) is defined as the person being aware of his or her own feelings, state of mind and emotions; and communicative contact (with the Other) refers to the person's capacity

to symbolise to others his or her reality and affective awareness (Prouty, 1990).

The emergence of contact behaviours should then be the logical continuation of the aforementioned developments, as the client expresses progressively greater contact with his or her (affective) inner world, with the reality of the external environment and with the reality of the world of the Other. The desired evolution would be the construction, or re-construction, of psychological contact, permitting movement from a first phase of pre-therapy to a second phase of conventional client-centred therapy, so long as the other five conditions are present.

Pre-therapy aims to establish the indispensable condition called psychological contact. This is a necessary prior condition for any psychological intervention to be able to take place, a fact also recognised by other schools of therapy. However, this does not exclude the possible need to complement psychotherapy with antipsychotics. These permit better discrimination between reality and fantasy, facilitating the development of contact and, consequently, of the relationship that is considered to be the cornerstone of the six necessary and sufficient conditions, as proposed by Rogers.

Based on the previously mentioned research, we conclude that in the psychiatric treatment of schizophrenia, the absence of psychotherapy is bad practice, as psychotherapy, undoubtedly, allows

patients to benefit from a process of maturation and elaboration, enabling them to better integrate their “being-in-the-world”.

Without intending to minimise the contributions from other psychotherapeutic models, we believe that the holistic model of Client-Centred Therapy has clearly shown its potential, a fact that justifies its presence in a wide network of European psychiatric institutions.

Finally we wish to state our belief in the importance of personal training in psychotherapy for psychiatrists during their specialist training.

Afterword

Reading this book allowed us to journey through the life and accomplishments of Carl Rogers, thanks to the author's careful description, highlighting a number of life experiences and choices which had a strong influence on his sense of purpose and the development of his thinking. One of the key ideas that stood out to us, and which goes against the view held by his peers of the time who took an interest in psychological intervention, is the statement that the person is a whole, a totality, a perspective which draws on the ideas of philosophers such as Aristotle and Saint Thomas Aquinas, by which access to individual essence is facilitated by the subjective understanding of what the person expresses as experience. This assumption will have led Rogers to explore, investigate and formulate theory on the effects of the type and the quality of the relationship on the psychotherapeutic process.

In Portugal, João Hipólito has played, and continues to play, a vital role in the dissemination of Rogers' thinking. This, expressed in countless writings tracing the development of Rogers' theoretical formulations, is incorporated in the first chapters of this book. Adopting the perspective of the Rogerian community in Portugal, the author describes Rogers' undisputable contributions to the Human Sciences and how his ideas, given their human complexity, spread

from the field of psychology and psychotherapy to the whole universe of Human action and understanding.

This diffusion of Rogers' theory is reflected in the progressive enhancement of the practice of psychotherapy and other forms of intervention, addressed by the author in subsequent chapters, chapters which also bring to the fore, in a spirit of continuity and without detracting from Rogers' theory, the author's unique contributions to the understanding of human relationships. The applications of Client-Centred Therapy in psychodrama, relaxation therapy and family therapy, or the comprehensive approach to the problem of drug addiction, are all examples of significant contribution, solidly grounded in Rogers' work, which also serve to support technicians, trainees or professionals seeking to enhance their know-how in terms of the helping relationship.

The penultimate chapter of this book condenses the undeniable value of João Hipólito's legacy to the Person-Centred Approach, accumulated over four decades. His innovative and holistic proposal for the complexification of Rogers' self-theory of personality development is a valid tool for research and for understanding children and adults, from a humanistic perspective.

While a superficial reading of the final words of the penultimate chapter prompt us to ask, "is this how it ends?", by choosing to end the chapter in this way, the author reveals the essence and coherence of his thinking, without detracting from the philosophy underlying Rogers' conceptualisation – the idea that the Human Being, as an element of Nature, self-actualises through a universal process of complexification, in line with a subjective adapting to the surrounding *holon* that becomes a part of Him or Her, the imposition of an unavoidable circumstance.

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João Evangelista de Jesus Hipólito was born in the city of Lisbon, Portugal. In 1957, he enrolled at the School of Medicine in Lisbon. His decision to pursue a career in medicine was influenced by the ideas of Albert Schweitzer for whom the practice of medicine was also a mission in life. During his training, eager to learn and acquire knowledge, he worked as a volunteer in the Emergency Department of Santo António Hospital in Porto, under the direction of Dr. Oliveira Santos.

His medical training was interrupted by mandatory military service, and in 1963 he was on his way to Mozambique. In 1969, having studied at the School of Medicine in Lisbon and the School of Medicine in Porto, he earned his medical degree, the first to be conferred by the University of Lourenço Marques (now Maputo, Mozambique).

He returned to Europe to do his Ph.D. and specialise in Psychiatry and Psychotherapy, which brought him into contact with Dr. Barahona Fernandes and Dr. Carlos Caldeira, both advocates of a humanist stance in medical practice.

He completed his Ph.D. in Child Neuropsychiatry at the Geneva School of Medicine, based on a Neuropsychological theme, and specialised in Psychiatry and Psychotherapy, as well as in Child and Adolescent Psychiatry and Psychotherapy.

He was responsible for a Sector of the Medical-Pedagogical Service of Geneva University, where he also obtained the Swiss Federal Diploma of Medicine. He was Head of the Outpatient Psychiatric Services Clinic of the Canton of Fribourg and Chief Physician at the Platanos Clinic, a semi-private facility specialising in Drug Addiction and Alcoholism. He was also Head Physician at the Public Psychiatric Hospital in the Northern Sector of the Canton of Vaud.

He is or has been a member of about 50 scientific societies. Together with Carlos Caldeira, he has been one of the main figures behind the dissemination of Carl Rogers' thinking and therapeutic practice in Portugal, where he was also among the first to introduce the "Balint groups" movement. He was a founding member and executive committee member for the World Association for Person-Centered Counseling and Psychotherapy and for the Network of the European Associations for Person-Centred and Experiential Psychotherapy and Counselling, as well as for the Portuguese Association for Person-Centred Psychotherapy and Counselling, where he is Honorary President.

He has more than one hundred scientific presentations and publications to his name.
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