CLIENT - CENTERED AND FOCUSING:
ONE WHOLE THERAPEUTIC METHOD

Why did I choose this topic and this title? I attended many congresses of client-centered and experiential psychotherapy in the nineties and after 2000 – and at first I was naively astonished to find the focus more on the differences than on the connections. And of course with my students all over the years, the question: is it one therapy (client centered and focusing) has become crucial.
So I paraphrased the title of an article of Barbara Brodley (1990) *Client-centered and experiential: two different therapies* as well as an article of Richard Van Balen (1994) *Client-centered and experiential therapy: two different therapies?* with a question mark.

Yes: Client-centered and focusing are one whole therapeutic method – and I will try to explain why.

The tribes of the person-centered nation is the title of a book by Pete Sanders edited in 2004, taking up an idiom Margaret Warner coined in her article "*One nation – many tribes*". Pete Sanders wears the colours of the "classical tribe" and - as he points out - has been publicly called a "dinosaur", a "fundamentalist", "immature" and "rigid" over the years. On the contrary "the others", the non-classicals, are sometimes defined as not part of the community, as "outlaws", "not really person-centered", "focusing-centered" etc. The range in Sanders´ book goes from classical client-centered therapy, focusing-oriented therapy, experiential person-centered therapy to existential approaches.
Pete Sanders hopes his book to be a contribution that "we can start by listening to each other." He mentions the 5th International Conference for Client-centered and Experiential Psychotherapy (ICCCEP) held in Chicago, where the inaugural meeting of the World Association for Person-Centered and Experiential Psychotherapy and Consulting (WAPCEPC) took place in 2000, which is now called PCE for short (Person-Centered, Client-Centered, Experiential).
This process of listening or else non-listening did unfortunately already start with our two protagonists - **Rogers** and **Gendlin**.

So what are the differences, what are the similarities or connections between the two lines of therapy? I will try to analyze these questions along with the ÖGWG tradition initiated by Wolfgang Keil, summarizing the ÖGWG´s point of view: combining “the two methods”.

THEORY

I. BASICS (transparency II):

I. - 1. Theory of personality of Rogers and Gendlin, especially the notion of self

A - **Rogers**: The person-centered development theory of personality is based on a dualism on one side: the innate capacities of the baby, his structuring und integration aptitude – and on the other his responding environment. As Daniel Stern would put it: to "make sense out of the light and sound show" the baby is confronted with. So the child is able to organize his hypotheses with which it will be possible to face life. He organizes them in the RIGS (representations of interactions that have been generalized), the GERS (general event representations) and the EGS (representations of the evoked companion) – (cf. Ruth E. Klemm, pp. 71, 72, 74).

The actualizing tendency (later formative tendency) is the axiom and core concept of Rogers. This is leading to the concept of self actualizing tendency inherent to the human being, representing a bio-psycho-social entity. Under favorable conditions – and this is, as you all know, our possibility for psychotherapy – actualizing tendency and self actualizing tendency are not in conflict, respectively not dissociated. Under "conditions of worth" it may come to incongruence. The actualizing tendency is always "active" in one way or another.

Rogers (1959, p. 221 in: Koch-Buch) describes the "release" of the pent-up actualizing tendency as the capacity – and hence the willingness – to "reorganize his self-concept in such a way as to make it more congruent with the totality of his experience." (cf. Van Balen, p. 117 in the Gmundner Kongressband). The self/self concept is on the one hand regarded as providing the basis for the self-experience-processes and on the other hand the self emanates from these processes. The self is an organized configuration, at any time forming a unity, but still fluent, changing. It consists of self-experiences, experiences with the others and the world and the evaluation of these experiences.

B - On the other hand, **Gendlin**´s concept of the self is even more conceived as a flowing river in which you "can or cannot"/ "may or may not" dip into. With Gendlin you have the choice to interact with your self-process by answering to it – you have to trigger it,

touching the felt sense which is not yet touched, for example. It is pre-conceptual – the already felt, but not yet known, e.g. of a situation, of a problem. Theoretically we can always have a direct reference to our experiencing. But this carrying forward order is sometimes not lived, not "active" in the sense of Rogers´ actualizing tendency.

In 1958 **Rogers** still writes (cf. Van Balen, 1994 – *Selbst-Verständnis*, p. 85): "**Gendlin** has called my attention to this significant quality of experiencing as a referent. He is endeavoring to build an extension of psychological theory on this basis." (1958a, p. 150). So - in the late 50^{ies} Rogers himself moved "from rigid structure to flow, from stasis to process." (1958a, p. 131). Earlier than Gendlin he emphasizes (1958, p. 148) the verbalization as postponed to the pre-conceptual meaning emanating from bodily felt sense of a situation (cf. Van Balen, p. 119 in the Gmundner Kongressband).

I. - 2 . The ethiology of illness

A - For **Rogers** it is the "conditions of worth". Recently Margaret Warner (2009 PCEP Journal Person-Centered and Experiential Therapies vol. 8, number 2, p. 117) brought attention to the fact that if you extend the "conditions of worth" to any sort of emotional or physical neglect, trauma or abandonment that occurs during childhood, the definition is too broad and therefore meaningless. But we should be aware that the "conditions of worth" cannot possibly be the only source of suffering, of incongruence.

B - With **Gendlin** it is a blockade of the experiencing process which can be stopped or/and skipped, overleapt. Rigid self structure, frozen wholes, split experiencing (two contrary impulses), sheer emotions, problematic reactions which I do not find adequate, the inner critic, rationalizing, self-engineering, fragile dissociated processes, dreams, hypnosis, pre-expressive experiencing etc. … are forms of this structure-boundness.

The "intellectual" question why this blockade of the experiencing process happens is not of interest for Gendlin, because it does not seem to alter the bodily felt sense.

I. - 3. The factors in therapy that enable the reorganization of the self-concept, enable change and movement

A - **Rogers** (transparency III) believes in the atmosphere of growth and therefore is non-directive in his method.

B - **Gendlin** intends to trigger the Felt-Sense, even if it is not yet there. "One exists in one´s bodily felt preconceptual, endlessly differentiable (implicit) experiencing."

II. THE ATTITUDE OF THE THERAPIST

A - **Rogers** himself started around 1960 (1957, p.99) to enhance the importance of the therapist´s congruence in the service of empathy (cf. Van Balen in Lietaer, p. 69). The congruence was part of the conditions, but now transparency is asked for. "At times he (the therapist, LK) may need to talk out some of his own feelings (either to the client or to a colleague or supervisor) if they are standing in way of the two following conditions." The non-directivity is now overcome, the accent of the therapist as an alter ego to provide a growth enhancing climate – Lietaer called it even "the phobia of influencing" (1983, p. 86 – cit. in Lietaer, Van Balen, p. 78) And not only the famous Buber – Rogers encounter might have had an impact on Rogers concerning this subject.

B - **Gendlin** at that time points out the importance of the interactional character of therapy. For Gendlin the attitudes of the therapist are not effective because the therapist "possesses" them, but because they have to have an effect on the client and orient the therapist towards adequate interaction. For the sake of brevity I will not go into detail - there is an ongoing discussion about perceiving and receiving on the 6th of Rogers´ conditions. Gendlin sees the interaction as one event – from two different frames of reference, the therapist´s and the client´s.

II. RESUMEE

I could continue finding differences and/or similarities for quite a time, but quotations of our protagonists shall round this up – quotations where they are again "in line":

A - **Rogers**: "This is not to say, however, that the client-centered therapist responds only to the obvious in the phenomenal world of the client. If that were so, it is doubtful that any movement would ensue in therapy. Instead, the client-centered therapist aims to dip from the pool of implicit meanings just at the edge of the client´s awareness (Rogers 1966, p. 190 – cit. after Van Balen in Lietaer, p. 72) …. or:

"… in client-centered therapy, there has come to be a greater use of the self of the therapist, of the therapist´s feelings, a greater stress on genuineness but all this without imposing the views, values or interpretations of the therapist on the client." (Rogers 1974, p.11 – cit. after Van Balen in Lietaer, p.77) - *and:*

B - **Gendlin**: "The client remains the center" (Gendlin 1968, p.221 – cit. after Van Balen in Lietaer, p. 72)

But the followers putting their emphasis on the differences see two main points:

1st difference: Rogers trusts the process of the client, Gendlin is the expert of the process of the client.

2nd difference: In client-centered theory the change occurs through the attitude of the therapist – self exploration only happens in a sufficiently safe atmosphere, whereas in experiential therapy change happens through the "therapist´s functions as monitor, director and teacher of focused experiencing" (Gendlin 1984, p. 82 cit. after Brodley in Lietaer p. 94) So it would rather be focusing-centered than person-centered therapy!

PRAXEOLOGY

I. Höger´s pyramid (transparency IV)

Now let us come down to the ground: What is it all about the "schism"? One could argue superficially: Do you have the permission or not to use skills / techniques in client-centered therapy? Rogers (1957 cit. after Van Balen p. 98 in *Selbst-Verständnis*) was definite about this: Yes, if they are carriers of the attitudes defining the client-centered psychotherapeutic relationship.

To reinforce this argument I will show you Höger´s pyramid of relationships - therapeutic relationships, clusters of interventions and pure interventions.

In psychotherapy it is possible to make a differentiation between four different levels of abstraction. Those four levels are in a hierarchy – they relate to each other logically.

The "Therapeutic Behaviour" ("What do I actually do as a therapist!") on levels 3 + 4 will have to correspond, will derive from levels 1 + 2. But on the other side, the concrete therapeutic interventions will be set in front of this client, concerning his/her specific situation or problem, at this very moment of our therapeutic contact, in the mirror of our whole therapeutic relation. So this specific therapeutic situation and the answer of the client to this concrete intervention will decide, if this intervention was in fact in harmony with the six Rogerian Conditions – for example if empathy in this specific case meant to understand the client or, for example to understand that he or she did not want to be understood.

II. Specific interventions on 5 different stages (transparency V)

I will briefly propose my order of specific interventions depending on the level of suffering, of disturbances of the client, where I tried to combine the "two methods" on a practical level.

II – 1: <u>Stage 1</u> (transparency VI)

When the self-exploration process of the client can develop undisturbedly, i.e. in a self-empathic, self-esteeming and congruent way, the therapist – in focusing-terms – is able to persistently focus with herself, thus following her client´s process which has the necessary therapeutic depth. She can abide with her stream of experiencing – in view of her client´s stream of experiencing - without faltering, she is present in the best sense. Concerning interventions that means, that "deep listening" in the sense of **Rogers** or else Saying Back as one of the "Listening Qualities" of **Gendlin** is enough. Here the therapeutic relationship is characterized by interest and attentive listening in the sense of unconditional acceptance, which is for example expressed by empathic repetition.

II – 2: **<u>Stage 2</u>** (transparency VII)

In the strict form of Person-Centered Psychotherapy this kind of intervention, namely triggering a Felt Sense when it is not yet there, is not considered person- but focusing-centered.
We witness for example during a session with a generally lively client that in certain situations only interpretations or conclusions of his/her experiencing are "admitted". It may also be the case that the client simply has "unprecise, woolly feelings", or that he "jumps to and fro" between different inner positions. Should this apply, the client has come back to structure-bound experiencing. (**<u>Gendlin</u>**) – with **<u>Rogers</u>** it would be incongruent.

Sometimes we manage to understand the client in his problem (incongruence) just by being empathic. But with "structure-bound" incongruent experiencing the therapist fails to be naturally empathic: She feels for example diametrically opposed to her client, or also instead / in place of her. This happens in stages 3,4 and 5 too, but on a different level – as we will see.
In this case the therapist´s attentive focusing with herself becomes more central. There is a multitude of possible interventions ranging from "How does it feel ...?" to "Something in you says..." to interventions on all modalities and many more.
After a Guiding/Leading step of the therapist it is however advisable to accompany the client´s experiencing again soon afterwards: the rhythm of the session, its style, should not be shaped or controlled solely by the therapist. Again the interaction between therapist and client is characterized by curiosity, concern and unconditional positive regard. Leading/Guiding steps are meant as means in order to clarify the client´s inner world. Interventions can help to make things more concrete, respectively to encourage an organism -based understanding and/or the client´s frame of reference (self-concept - based understanding). In this context the therapist may offer biographic bridges too.
Concerning the relationship of client and therapist on these first two stages, I believe that both the client and therapist coexist side by side, they jointly look at something. There is a parallel with mother and child, who lay a joint focus on something too – in the case of client and therapist they focus on the client´s "inner world", his/her felt sense.

II – 3: <u>Stage 3</u> (transparency VIII)

On stage 3 the therapist does not primarily focus on the themes, the topics, but rather on the "how-s" of the client: How is for example his voice: Beseeching? Competitive? .... The "drive" could come from there.
These structures can however be accessed by self-perception only arduously. Partners of clients notice these structures, but in everyday life mostly react in a way that solidifies them, that amplifies their protective function. Of course this applies to therapists as well! But the therapist is required as a counterpart, as somebody reacting "different to all", in order not to additionally solidify his client´s structures. The relationship between therapist and client, the role of the counterpart, the interaction emerging from this relationship become more essential now than on stage 2, where a "friendly side-by-side" of therapist and client is sufficient.
In this field the accent lies on the therapist´s part – in a kind of "encouraging confrontation". The client needs appropriate responses to find a way out of his stereotypes.
Stage 3 involves both clarification of relationship and congruence, for example confronting, self-opening and/or self-participation. Jobst Finke (2007) enumerated and differentiated all these interventions very clearly – staying close to **<u>Rogers'</u>** concepts.
Two items are as always important in this field: empathic knowledge of disturbances and the thorough focusing of the therapist with herself. The knowledge of disturbances may arise from different sources: from developmental psychology, from clinical psychiatry, from the body-based field, from the arts, etc. This knowledge of disturbances has to be empathic in order to facilitate the experience of constructive relationships. Without empathic understanding, the therapist´s positive regard and congruence are threatened, too – and vice-versa.
As always the part of the client where he/she is a victim has to be bemoaned, his/her anger has to be sensed and expressed. On the other side it is essential to look at the "active part" within a client, where he/she "commits" things, where he /she is the "doer".
In our free-lance practice these clients are mostly our "daily bread". They intellectualize, they rationalize in the fashion of "I am not well, because ....so and so...." without really living or experiencing it. We are now in the field of "neurotic" disturbances.
Here structure-boundedness in **<u>Gendlin´s</u>** sense is more severe than on stage 2, the barrier to arrive at experiencing is higher. I still basically presume the possibility for self-exploration, but neither emerging on its own, nor simply resulting from "slightly triggering" interventions to activate the experiencing-process. The difference to stage 2 is gradual - the clients´

liveliness however is restricted in many fields, their “disturbance/perturbance” is more obvious and distinct, the incongruence (**Rogers**) more visible.
Still it is generally possible to reach disowned (but available) or distorted organismic experiences – that is how **Rogers** would put it and his shift would be to more congruence.

II – 4: <u>Stage 4</u> (transparency IX)

Heinerth (2002, p. 145 ff) speaks of locked rooms where specific aspects of the self had no possibility to develop, by lack of empathic understanding in early childhood or later. Stage 4 is the field of personality disorders and psychosomatic illnesses. There are of course progressive junctions to both stage 3 and 5. Client-centered psychotherapy is considered to be highly effective with "early" heavy disorders. Furthermore the practice of focusing has first been used in psychiatry.
As we see it is of high importance on this stage to place oneself at the disposal as a person. It means to "unlock" the rooms together in the sense of a "work in progress", "under construction". To place oneself at the disposal as a person also means that sometimes "substance" is not yet there, but is to be developed through interaction.
According to **<u>Gendlin</u>** we innately know "how things should be" and can also get back to this knowledge. Our body is provided with an innate "environmental knowledge".
The therapists are as well able to hark back to their clients´ inner knowledge: In this respect *Refilling* is the magic word of focusing – Refilling being however not solely a special technique of focusing, but something we are acquainted with from several methods of psychotherapy. Again the emphasis lies on the therapist´s accurate and attentive focusing-processes with herself.

Just in addition person-centered/client-centered therapists and theoretical researchers like i.e. Heinerth or Ute Binder elaborated this holding/containing function aswell . And Rogers himself was a good example (to quote once again his therapeutic session with Gloria: "You would have been a nice daughter").

This quality of the client-centered psychotherapy is often considered as "typically female": the filling, the refilling, the building, the rebuilding. Empathic knowledge of disturbances grows even more essential.

Refilling may be initialized by additional questions like:

- What would have been right / appropriate then? What is it you would have needed? What was missing? (that is, to work with and through the inner child – viewing the past)
- What do you need now, what is now right / appropriate? (that is, to work with the here and now)
- How would it feel, if the problem had already be solved? (that is, the "magic question" for the future)

"Refilling", respectively first-time filling can be performed in different modalities:

- by simply being present; as sensing fellow man/woman, as witness
- by suitable imaginations ("Imagine being the mother / the father of this child..", or "I call upon your 'wisest' part")
- "Write a letter to your mother / your father – and answer this letter in a way you would have wished your parents had done."
- but also by real bodily contact with the client.

II – 5: <u>Stage 5:</u> (transparency X)

The last stage 5 is just to be mentioned to complete the scenario.
On stage 5 the therapist´s resonance will be confused, anxious, chaotic. How can I maintain relationship – how can I establish relationship "to her/to him who is ʻin there'?" So expert knowledge in the sense of "empathic knowledge" is (again) in demand, just as a highly developed competence in relationships – also out of the focusing-processes of the therapist.
As we know from many publications it is primarily a question of the first of **<u>Rogers´</u>** necessary and sufficient conditions, namely psychological contact. On stage 5 the accent lies on the preservation or, when interrupted, on re-installing the psychological contact (anew) over and over again. This can be achieved by an empathic being-and-staying-present in order to guarantee the continuity of the client´s experiencing, thus creating firm ground together with the clients. For most of the clients it is (has been made) impossible to (be allowed to) sense themselves. The therapist will offer her experiencing out of her resonance, if appropriate. At the beginning the therapist will well understand that her client cannot keep attention on her experiencing – later on she will carefully lead her to get into contact with her experiencing. In the long run the experiencing-process has to be kept on a tolerable level – what means not too far and not too close, like in a focusing process – something which could not be achieved at the beginning of therapy.
Warner (2000) describes how fragile self-experiencing of traumatized / sexually abused clients manifested itself: namely either by being swamped by experiencing, or / and non-appearance of experiencing. These patients have difficulties in keeping their experiencing within moderately intense awareness. Often excessive shame also characterizes these processes.
For post-traumatic clients, Coffeng (2000) develops a huge variety of possible interventions – from general principles like the client as the expert, or the respect for the symptom and rhythm of the client, right up to working with the inner child. He also arrives at "stricter principles" like special mindfulness towards the clients´ bodily limits, as well as to specials like establishing "witnesses" or drawing on ideal parents. Coffeng chiefly refers to **<u>Gendlin</u>** and in his pre-symbolic contact reflections to Prouty.
For psychotic experiencing or else non-experiencing, Prouty (1994) has established a number of contact reflections performing the task to enable the therapist to work with schizophrenic, autistic and developmentally retarded patients: from pre-therapy to therapy.

THEORY AND PRAXEOLOGIE

I. Wolfgang Keil´s attempt to connect "the two methods" in theory (transparency XI)

A - **Rogers** respected the potential, the resources of the client and therefore postulated that the conditions to promote personal growth are sufficient. The proposed relationship of the therapist was necessary and sufficient.

B - **Gendlin** focuses on the client – the way being with himself. As Wolfgang Keil would say: the sufficient depth for experiencing on this psychotherapeutic level: A bodily felt sense – on an existential level to be with myself, the others and the world.

Rogers used **Gendlin´s** termini, but not consequently enough to integrate them in client-centered psychotherapy. It was Wolfgang Keil who made this attempt, thus promoting experiencing on this deep level not only for the therapist, but for the client as well.

We are coming to the end – let me shortly resume:

Wolfgang Keil´s attempt to integrate the "two methods" was on a theoretical basis, comparing **Rogers´s** conditions to **Gendlin´s** keeping the track on the focusing process. Wolfgang Keil filled the blanks by proposing the experiencing on a deep level for the therapist AND THE CLIENT.

II. My attempt to connect "the two methods" in praxeologie

(Transparency XII)

I tried to solve the problem on the levels 3 + 4 of Höger´s pyramid – the cluster of interventions and the interventions themselves – using likewise allowed and "forbidden" techniques.

But remember **Rogers**: "Every intervention is possible if they carry the attitude"
and **Gendlin**: "Client-centered is the bigger thing"

Thank you very much !

Aplause...
Smile