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The Challenges of Person-Centred Relationship Therapy

Having lived among family and couple therapists for many years, I will present some of their ideas and techniques that I find compatible with the six conditions of effective therapy outlined elegantly by Carl Rogers over 60 years ago. In this chapter and Chapter 2, I will offer a personal tour of my approach to couple and family therapy, briefly discussing therapists whose post-modern approaches to families, including narrative therapy, share core person-centred values.

In this chapter, I will also present what clients say are their goals in relationship therapy and discuss three challenges for all couple and family therapists that lend themselves to a person-centred approach:

- multi-directional partiality;
- use of relationship knowledge and skills;
- and active facilitation.

I offer reflections on the specific qualities of a person-centred approach, including the first presentation of Rogers’ core conditions for therapy. A final case example shows a therapist at work, integrating a person-centred approach with a family therapy perspective.

The World of the Relationship Therapist

Relationship therapists always work in between co-existing, different realities. In practice, a therapist cannot get completely absorbed in tracking an individual’s process without attention to the reactions of others in the room. Similarly, any description of a group condition must co-exist with awareness of its effect on each individual’s perceptions and
self-concept. The therapist never stops being a translator looking for points of understanding among very different internal countries.

Research shows that the therapist/client relationship does not only depend on therapist qualities such as empathy and acceptance; it is also important that clients see therapists as aligned with their spoken and unspoken goals (Sprenkle et al. 2009). Couples come to therapists because they cannot talk to one another without inhibition, discouragement or real or feared rejection. Families come either because something seems to have gone wrong with one or more children, or because the children’s progress from one stage to another has caused emotional unbalance involving fear, anger, disconnection or discouragement. Every therapist must not stray far from each client’s expressed or implicit goal, both as they state it in the beginning and as it evolves.

What Do Clients Want?

Here are some goals that I commonly discover with my clients:

- To be able to be their authentic self without losing the love and approval of their loved ones.
- To solve a problem or to return to a better level of cooperation in the face of a complex predicament.
- To be able to talk cooperatively with one another about ‘the great thing in the middle of the room’ (Palmer 1997), whether it be sex, money, parents, child development, dreams, disappointments, transitions, individual growth, grief or the loss of ‘the way we used to be’.
- To have their shortcomings overlooked, accepted or at least not to be the subject of scolding and shaming.
- To have their strengths remembered and noted at least as much as their failings.
- To be respected: not to be yelled at but also not to be ignored.
- To be able to back away and be left alone when they want to be.
- To be noticed for their own sake rather than as a subject of someone else’s expectations.
- To express their ideas of what is fair and appropriate.
- To be given a second chance if they have made a mistake, misbehaved or otherwise disappointed a significant other.
- To have their reasons for acting in a way that displeases their loved ones at least acknowledged, occasionally understood and even sometimes validated.
● To be able to manage family cohesion while the drama of growth pushes towards separation.
● To acknowledge losses, impasses and disappointments without resorting to blame, rejection, threats and rigid categorization.
● To be able to adjust to ever-changing boundaries, authority, availability and norms of mutual respect.
● To have a way to carry all these experiences out of the therapy office into their day-to-day lives.

There are also goals specific to couple therapy (see especially Greenberg and Goldman 2008a, b; or Moser and Johnson 2008):

● To resolve problems of closeness: more affection, more security in attachment.
● To be able to return to moments of perceived mutual or individual injury and begin the process of repair without repeating the injury.
● To resolve problems of power, significance, respect, autonomy and identity in a relationship context.
● To identify, resolve or learn to live with pressures from children, ex-partners, families of origin and friends.
● To restore friendship.
● To stop fighting and to stop avoiding talking about significant issues.

The World of One Relationship Therapist

What does couple and family therapy mean to me in the hours in which I practise it? Having been introduced to therapy from the person-centred approach, I am a listener who does not intend to judge or control. I also have a hundred ideas in the back of my mind, derived from 35 years of systems therapy-related reading, training and practice. All those perspectives are part of me: not external techniques I laboriously drag out, but possibilities that naturally emerge in meetings with clients. Below are nine ideas, from diverse therapy traditions, that are my constant companions and will be illustrated throughout this book. I offer them as a description of my own integration of theory and practice rather than as a prescription for the reader. Each family and couple therapist can seek their own path to useful, caring relationship facilitation.

below and especially in Chapter 4, the interaction of empathy, acceptance and realness is the beginning and end of my work. I meet with people and join them in invariably confusing circumstances and competing beliefs. My core centring, always useful, intervention is to stop and listen and seek to understand from clients in a non-judgemental way. There is no systems intervention more essential. All the perspectives listed below enhance the clients’ experience of these conditions or are not helpful.

2. **Reframing.** The heart of all systems therapy (Framo 1996), changing the core description of an interpersonal predicament or problem in such a way that wider lens perceptions are allowed, dialogue is encouraged and positive possibilities can emerge. Family therapist and teacher Jim Thomas says, ‘In family work, it’s a different take: unconditional positive regard requires reframing’ (personal communication). Family therapy models, writes one theorist (Beels 2009), ‘when stripped of their theoretical dressing are ways of focusing a common agreement in a room where two or more people feel passionate disagreement about the meaning of the experience’. The listening therapist seeks to translate raw interpersonal distress into a predicament that can be discussed with less blame, fear and provocation. Almost all the therapist’s statements have qualities of reframing. Person-centred empathy reframes client words simply by the transformation of something said tentatively, passionately or even provocatively into something that is heard respectfully and taken seriously without judgement, defensiveness or drama. Relationship therapists listen closely, finding within impossible (accusatory or hopeless) conversations the core needs and wishes that drive them. The art of therapy is to provide fresh language without suppressing urgent feelings.

3. **Dominant story/alternate story.** This concept from narrative therapy (White and Epston 1990) allows whatever distress clients express to be retold as part of a story that has emerged in their lives rather than as a symptom of intrinsic inadequacy on their part. This therapist always looks for a narrative that describes a whole experience in a way that includes all participants. The concept of the dominant story is a most imaginative form of systems thinking: people are seen as living in a virtual, prescribed dramatic scenario in which their choices and experiences are limited and disabling. Naming a story and inviting clients to comment on or add to it allows the opportunity for the clients to remember their own ability to choose their responses in the face of that story. The therapist holds an active
curiosity about what alternative, overlooked, more encouraging story may co-exist and offer resources to clients. Here is the story that I am hearing so far,’ a therapist might say. Later that therapist might say, ‘I am meeting two people who are living in a sad house. Your marriage has become this place of “never saying or doing the right thing” rather than the new land of closeness and pride you expected it to be. Do I have this right?’

4. **Taking the ‘I’ position.** This concept, from family therapy founding father Murray Bowen (1978), represents a way of being in one’s family of origin and exactly parallels the intentions of a congruent person-centred therapist. Therapists speak their own truth without attempting to impose that truth on another. The direct sharing of a therapist speaking from within a situation *without an agenda for others or judgement of them* is central to clients’ experience of an opportunity either to accept themselves and others or to initiate change. The therapist is a person first and a therapist or expert second. Claiming the freedom to speak for oneself in a respectful way invites clients into a calmer form of conversation, in which they don’t have always to be right or even on someone else’s point in order to be heard.

5. **Externalizing the problem.** This is the core expression in narrative therapy of an old therapeutic tool found in Jungian psychology, psychodrama and Gestalt therapy: finding a way to *personify* common sources of distress for all members of a couple or family rather than locating trouble in the persons within the group (Freedman and Combs 1996). For example: ‘The Land of the Perpetual Fight’; ‘Nagging mother/frustrating teen’; ‘The “can’t-do-anything-right family”’. Each phrase is helpful only if it allows clients to see themselves as caught in a pattern rather than as personally in the wrong. I may frequently say, ‘The American (or British, or Italian etc.) *idea of marriage* is out to get this couple.’ This last is a favourite of mine: almost invariably, clients are discouraged by the difference between their own relationship and an idealized relationship that they feel they *are supposed to be having*.

6. **Asking reflection-oriented questions.** This invokes client curiosity and the possibility of creating a different process. Influenced by the ‘circular questions’ of the Milan group (Boscolo et al. 1987) as well as the questions developed by solution-oriented practitioners (de Shazer 1982, 1994; Berg and Miller, 1992), therapists make enquiries that allow unspoken hopes, fears, memories, disappointments and possibilities to emerge. For example: ‘What were things like when
you all did get along, even back in the 1940s? ‘Who in your life do you think would be most convinced that you can solve this problem?’ ‘What would your best friend wish we were talking about?’ ‘How do you think your parents would react if they were in the same situation are you are?’ When clients have managed something they had thought impossible, I may ask: ‘What do you think may now be possible for you, now that you have (“finished high school”, “got this job”, “managed a weekend in which you didn’t fight even once”).’

7. **Holding and expressing awareness of human development and consequent change in roles, boundaries and hierarchy.** These core ideas of structural family therapy (Minuchin 1974; Mitriani and Perez 2003) help make family distress more understandable than the blame–disappointment orientation that can emerge in an individual’s perspective. Every person changes with time and thereby affects the self-concept of every other person in their life. The role and security of a parent may be threatened by the greater autonomy of a child; a woman’s great sense of her own needs and rights may be a threat to both her partner, her children and other family-of-origin members. This awareness can normalize (allow events to be seen as natural and predictable) troubles that otherwise would be considered signs of inadequacy or bad intentions.

8. **Spatial arrangement, movement and other choreography.** Family therapy founding mother Virginia Satir used every inch of space in whatever setting to allow clients literally new perspectives (Satir 1972; Papp 1983). As a way of responding to many seemingly opposed descriptions of trouble, I frequently stand up and walk around to locate different aspects of the situation in different parts of the room. I may invite a couple to move to two different chairs so that they can leave the ‘fight’ back where they were sitting. Using movement on the part of clients as well as the therapist is especially important when children are part of the group. More important than any single action is the knowledge that I, the therapist, don’t have to sit in the place of distress but can move about in search of non-distressed possibilities.

9. **Enactments** (Mitriani and Perez 2003; Butler et al. 2008; Moser and Johnson 2008). Clients can be frustrated by the difference between their less anxious, more civil behaviour in therapy and their frustrating interactions at home. In enactments, clients replicate a form of their conflict at home in the office where:

- each person, including the therapist, can stop the action and report on what they are feeling;
each person can share observations about what the conflict means and what alternatives to it could look like;

- the clients could try out other ways of expressing or responding that would give the interaction a different meaning or outcome.

Enactments can bring clients’ worst experiences into a climate in which empathy, realness and acceptance allow changes in perspective and in behaviour.

A person-centred couple and family therapist, as jazz musician Wynton Marsalis says, responds to what other players in the room offer; they contribute their own sound but don’t impose something that doesn’t connect with what is already there. The purpose of the perspectives and tools described above and any other techniques is to provide resources that facilitate conversation in which clients feel heard, safe to be themselves, empowered and respected. An experienced systems therapist may ask themselves what are their own core attitudes and techniques and why. My own attempts to find a way of conversation that joins with my clients’ own voices parallels the work of the therapists briefly described in Box 1.1.

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**Box 1.1: Collaborative, Post-modern and Dialogic Therapies**

Post-modernism is a term that is applied to such therapists as Harlene Anderson, Lynn Hoffman and Peter Rober, all of whom are part of my internal chorus of encouragers as a relationship therapist. Post-modern refers to a family of concepts that have developed among scholars … that call for an ideological critique – a questioning perspective – of the relevance and consequences of foundational knowledge, metanarratives and privileged discourses, including their certainty and power for our everyday lives (Anderson 1997).

Though Harlene Anderson describes her writing as a ‘philosophy of therapy’ rather than a theory, her use of language has practical consequences: no one defines a person or their difficulties from outside; the nature of problems changes through family interaction characterized by listening and respect. These ideas have urgency, for example in therapy with minorities such as gay and lesbian couples, discussed in Chapter 6. In practice, Harlene Anderson sees therapy as a conversation among equals in which each member of a family has their own story about what their family is. Listening to each story allows language to be ‘relational and generative’ and brings about a new, co-constructed reality for clients that can be ‘transformational’. Comparing herself with Carl Rogers, Anderson (2001) identifies with his client-centredness and rejection of diagnosis and other positions that make the therapist expert and in control. She distinguishes herself from him in being a more
active conversational partner and being more ‘public’, sharing more of her own voice in the therapy. Famously, with her colleague the late Harry Goolishian she has written about the ‘not knowing position’ (a term used also by person-centred therapist Peter Schmid 2002, 2004), which refers not, of course, to therapist’s lack of knowledge but to openness to learning from the clients’ own words and presentation (Goolishian and Anderson 1992). The therapist comes to each meeting without ‘prior knowledge’ about what the clients’ situation and feelings might be and seeks to understand what the client understands without translating it into the language of the expert helper.

Lynn Hoffman is a family therapy elder whose biography associates her closely with the earliest family therapy theorists, such as Jay Haley, Virginia Satir, anthropologist Gregory Bateson, Salvador Minuchin and, especially in later years, Harlene Anderson, Harry Goolishian and other post-modernists, as well as narrative therapist Michael White. See her Family Therapy: An Intimate History (2002) for her rich life finding her own voice among all these originals. Hoffman offers a personalized and free exploration and integration of all family therapy ideas and encourages practitioners to expose clients to those ideas without imposing them as an expert. In support of each meeting with clients as a unique experience, she encouraged ‘Setting aside the model’ (1998), any model that makes the therapist the holder of privileged truth. Hoffman (2002) offers many conditions for her integrated, centred-on-persons approach to therapy, including the following:

- ‘Embracement’, which is a form of acceptance that is open to all clients as well as their whole situation.
- ‘Tempathy’ or ‘traveling empathy’, which refers to therapists’ openness to their own voices meeting with client voices and the sharing of images that emerge for client reflections. Hoffman encourages reflective involvement in client situations, with the results of therapist intuition made available for client use.
- ‘Generous listening’ – that is, not ‘listening in order to speak’ but ‘speaking in order to listen’.
- ‘Knowledge of the third kind’. This term from John Shotter (1993) refers not to theoretical knowledge (knowing that) or even practical knowledge (knowing how), but knowledge that comes from being within a situation – knowing from lived experience. The therapist brings their experience, knowledge and professional training into a meeting about which they cannot know and of which they do not control the outcome. What they do contribute is readiness to respond to what is present. Although they have many thoughts and skills, they offer what is called for in the interaction rather than anything they can prepare. They bring a way of being to the therapy that is instinctual as well as cognitive; personal as well as professional.

Peter Rober is a Belgian psychologist who also looks to ‘knowing of the third kind’ to describe his approach to ‘dialogic family therapy’ (2005). Rober quotes Shotter (1993: 40–41) regarding knowledge ‘in terms of which people are able to influence each other in their being, rather than just in their intellects: that is, to actually “move” them rather than just giving them ideas’. Exploring dialogue in a series of articles (1999, 2002, 2005, 2008) that capture the ‘therapist’s inner conversation’ (2008) as well as the many levels in which clients’ words may be understood, Rober
describes a therapy of respectful presence in which therapists listen to clients’ voices and their own voices simultaneously. Regarding family therapy, he reminds us that dialogue is continuous and that every therapy session enters an ongoing dialogue that preceded the session and will continue after it.

I am at home in the world of post-modernists, but I do not identify specifically with their or any philosophical approach. This book describes therapy steeped in Carl Rogers’ clarifying basic principles that allow client autonomy and growth within a systems perspective. Like Hoffman, I feel free to borrow generously from therapies that preceded post-modernism without complete allegiance to their theories. All authors about relationship therapy have in common thousands of hours in the presence of families or couples: their activity, their decisions not to act, their way of configuring family distress and family resources.

The Purpose of Relationship Therapy

Relationship therapy facilitates the, sometimes elusive, process of being a differentiated person – a separate ‘I’ – who must make autonomous decisions and live with complicated feelings while remaining part of an intimate group capable of mutual support, understanding and appreciation. In her hundreds of public demonstrations, family therapy founding mother Virginia Satir used to connect all family members with ropes and encourage them to move about. She thus illustrated that one person’s motion necessarily exerts a pull on every other person. Each movement of other people pulls the original person. (See Chapter 3 for a more detailed discussion of systems thinking.) Family or couple therapy becomes necessary when clients are, so to speak, pulling one another in opposite directions, or when one or more people are paralysed for fear of pulling or being pulled too hard or in the wrong direction.

The purpose of family therapy, says Peter Rober (2005), is to find ‘a way to get on’. Harlene Anderson says that it is to have ‘problems not solved but dis-solved’ (1997). She means that changing the nature of conversations changes what couples and families face (1997: 108–31). When couples and families come to see me it is because they cannot talk with each other about their real needs and troubles, and instead must choose between blaming, fighting and avoiding talk of what is most important. A therapist facilitates a way to bring troubling topics into a room without driving people out. Family therapy offers clients a way to
grow in each other’s presence rather than privately struggling with discouragement and frustration. Relationship therapy facilitates individual discovery with respect for its impact on family connectedness. A good relationship therapist facilitates discovery of unseen family group patterns, with attention to the implications for individual self-concept. The therapist also looks for unexpected, understated changes in individual self-concept that may open doors for system-wide change.

Contemporary couple and family therapists have many issues to resolve for which a person-centred approach may be helpful. They must be engaged without being reactive; confident and knowledgeable without being superior or controlling. They must avoid getting trapped in ‘impossible therapy’ by feelings of urgency, anxiety, over-responsibility or pessimism, in Duncan, Hubble and Miller's brilliant formulation (1997a). Relationship therapy brings, among others, three challenges: the need for multi-directional partiality, a knowledge of the conditions and common patterns of couple and family life, and the need for active facilitation of change that is compatible with each client’s sense of self-respect and of timing. I now look at each of these important ideas in turn.

- **Multi-directional partiality.** This is crucial to relationship therapy and is the intention and practice of being on everyone’s side at the same time (Boszormenyi-Nagy et al. 1991; O’Leary 1999). In person-centred terms it is about contact/empathy of equal quality with everyone in the room. See Chapter 2 for a fuller discussion of this topic. The relationship therapist facilitates a meeting between different people who may be caught in complex habits and troubled by years of not feeling understood by one another. Person-centred therapy begins and ends with attention to each person’s unique perspective, while clarifying and validating other perspectives in the same room. The therapist models the expectation that contradictory interests must co-exist in order to allow conversation to take place. Most people, however good their intentions, have at least some negative impact on those they love most. Finding room for understanding the reality of negative impacts without denying good intentions requires a person-centred connection with both perceived victims and perceived offenders. It also takes the skill and personal authority to facilitate dialogue when hurt feelings are activated. For example, the therapist is understanding both of the young person who makes black-and-white pronouncements about his parents’ failings and of the mother or father struggling to find their new place in
their child’s life. The therapist, managing internal comfort with the fact that two things can be true at the same time, seeks to be a believable translator between seemingly irreconcilable inner realities.

- **Knowledge of the conditions and common patterns of couple and family life.** A person-centred therapist privileges clients’ own knowledge and ability to solve problems while consciously committing to know as much as possible about ‘how life is lived between sessions’ (Barrett-Lennard 2005). Clients need a therapist to be knowledgeable about life in a couple or family and to have skills that clients can use.

  Therapists cannot know everything and, wisely, never forget how much they do not know. At the same time, the more a therapist learns about contemporary relationship expectations, the more clients can feel that they are in the presence of someone who understands what their life is like. Knowledge can lead to deeper and more accurate empathy, while making the therapist a reliable collaborator in problem solving. Similarly, most clients eventually ask for skills to use when they are at home: the therapist may offer tools for communication, problem solving, a genogram (a type of family tree used in intergenerational therapies, to be described in detail in Chapter 3), printed guidelines, books and CDs that relate to the problems that the clients identify.

  Lynn Hoffman has written (1998: 153): ‘I have proposed a category called Biggest Hits of Family Therapy. Our field is full of wondrous things that we can use even if we do not accept the theories that produced them.’

- **Active facilitation of change.** Couples and families come to therapy for the resolution of problems and the unravelling of predicaments. A therapist must be an active facilitator who makes dialogue possible – someone who can ‘discuss all undiscussable issues’ (Schwartz 2002) and who also seeks to give a voice to all present and to acknowledge the effects on each person’s feelings. The therapist is listener, supporter and moderator, timekeeper and respectful process director. The therapist is in the sorting out business: seeing what issues belong to whom, which can be solved immediately and which must be understood better before being addressed, which are signs of an untenable understanding and which are just part of life. The good therapist encourages clients to find a description of a situation that encourages dialogue, deflects the tendency to blame and engenders human-sized hope. Finally, the therapist facilitates the necessary movement between acting for change and accepting lack of readiness to change.
Narrative therapy, briefly described in Box 1.2, provides perspectives and language that facilitate clients’ empowerment by discovering their identity that is separate from their problems, circumstances and definitions by others.

**Box 1.2: Narrative Therapy – Problem-Saturated Stories and Unique Outcomes**

Narrative therapy is work originated by the late Michael White and David Epston, famously described in their classic *Narrative Means to Therapeutic Ends* (1990), in Freedman and Combs’ *Narrative Therapy: The Social Construction of Preferred Realities* (1996) and most recently in Michael White’s last book (2007), *Maps of Narrative Practice*. Narrative therapy sees clients as ‘trapped in problem-saturated stories’ in which attempts to solve the problem often increase the power of the problem. In their post-modernist frame of reference, White and Epston see clients as identified with their problems by the social definitions of their immediate community as well as, in many ways, by the larger culture. Therapy consists, therefore, in changing the conversation in such a way that the client is seen as separate from the problem that distresses them and competent to reduce its influence. This is a therapy in which language is challenged as a potential means of oppression.

White famously asks questions that involve clients becoming ‘investigative reporters’ (2007) into their problems: how they have affected them; how they might be defeated; what plans the problems have for ruining their lives; and what strengths they and their other family members might have for getting them out of their lives. His questions exist ‘to generate experience rather than gather information’ (Freedman and Combs 1996: 113). His questions generate metaphors through which clients take positions towards changing the problems in their lives.

Narrative therapy engages imagination, wonder and especially, like the person-centred approach, the assumption that people have untapped resources that flourish when they are outside categories dominated by fear, blame or judgement. David Epston once said, ‘we must forever be realizing that people are multi-storied, just as our stories of culture and psychology are. For instance, what would have happened if Carl Rogers’ work had been the privileged psychological text rather than Freud’s? It would seem that we would have a totally different psychological world’ (quoted in Madigan 1994). In the world of narrative therapy as well as the person-centred approach, there is the way people are when diminished by what Rogers calls the ‘evaluative tendency’ (1961), similar to what White calls the ‘dominant story’ (1990). There is also the experience of freedom ‘to be the self one truly is’ (Rogers 1961) and the ‘intentional self’ (White 2007) when people are freed from external control and evaluation.

Narrative therapy offers a rich language for finding the effects of the actualizing tendency, a core concept of the person-centred approach, described below (Rogers 1980, 1959). The opposite of the problem-saturated story is the appearance of unique outcomes; that is, experiences in which a problem was expected to occur
but did not because of effort or imagination by clients. The concept of unique outcomes focuses clients’ attention on their resources, their unnoticed good habits and good practices and, in couples and families, on what they are like when they are not trapped in the story called ‘fight about everything’ or ‘we can’t get along any more’. I frequently send clients home with a small notebook and the request that they make note of such things as: ‘When you would usually be scheduled to fight but didn’t’ or ‘When (your partner) would usually disappoint you but didn’t.’ White encourages client and therapist to investigate each unique outcome with questions such as: ‘What is it that made it possible for you to listen rather than defend yourself?’ ‘What does it say about your relationship that after all you have been through you were able to make love that night?’ ‘What might be possible between you now that you know that you can get through a conflict and still be not only speaking to one another but each feeling like you are with a friend.’

Narrative approaches give room for the presence of understanding and compassion in a relationship field that is often swamped by negativity, fuelled by fear of rejection and unfairness. It allows for giving validity to the unspoken hope of closeness that does not deny frustration, grief and hurt. A couple and family therapist needs language in which to create a context for new events and reclaiming of old, supportive events that have been forgotten or buried by understanding and disappointment. The therapist can remain client-centred while creating space for couple and family members to take responsibility for attempting to understand as well as seeking to be understood.

Core Values in the Person-Centred Approach

What kind of person is the therapist, regardless of the particular model they use? David Bott has commented regarding family therapy:

Pragmatically, if we are seeking to humanize our practice and respond respectfully to families with a view to creating a context which empowers rather than subjugates, Rogers provides a clear, accessible and, above all, ethical position from which to do this. (Bott 2001: 375)

The starting points for understanding the person-centred approach are Rogers’ six necessary and sufficient conditions for helpful therapeutic meeting (1957), described below as applied to relationship therapy. Mearns and Thorne (2000) have described the six conditions as interactive, each inseparable from the others. Furthermore, they describe these conditions in terms of ‘becoming ready to meet the other’ (2000: 87–100). Each therapist, skilled and knowledgeable as they seek to be, is
always engaged in becoming a person whom clients will find trustworthy, affirming and encouraging. Without work on ourselves, we face the possibility of being the opposite. Rogers found that his six conditions allowed individuals to emerge from a pattern of blocked development. Family systems therapy in its myriad forms has had a similar goal.

Here is the first statement of these conditions applied to couple and family therapy:

1. **Psychological contact with each client.** The consistent intent to connect with each person present in every session facilitates change in the system of several persons.

2. **Awareness of a state of incongruence causing anxiety in both individual and system.** A person-centred therapist expects, accepts and works with incongruence: mixed messages, contradictory feelings, inconsistent or even deceitful behaviour. The therapist relates not with judgement but by attention to understand all and to acknowledge more congruent aspects of person and relationship.

3. **Therapist congruence (authenticity or integrity).** In order to be trusted for dialogue about clients’ most treasured relationships, the therapist must be personally integrated so that their words match their actions and their affect. Only a real person can be trusted with the deepest experiences of important relationships.

4. **Therapist unconditional positive regard.** Families and couples can become open and confident enough for change only if therapists are perceived as accepting each person as they are rather than judging.

5. **Therapist empathy.** Each person feels the therapist’s intention to understand their internal frame of reference – in relationship therapy, also to understand the shared predicament between persons.

6. **Clients perceive the above conditions.** Therapists share in whatever way will allow clients to experience therapist, realness, acceptance and empathy.

The person-centred approach is an outlook, a set of priorities and the result of a series of commitments. For every therapist, in every session, there is the path of the expert in control or the path of the collaborator, who is always centred on the experience of the clients. The person-centred therapist is biased towards client unfolding rather than fitting the client into any predetermined pattern. Such a therapist “(speaks) in order to listen” as opposed to “listening in order to speak”, as family therapy historian Lynn Hoffman (2002: 181) said about Carl Rogers. The therapist supports client control; is alert for overlooked potential; and
seeks the free expression of clients’ experience of truth without setting off judgemental assumptions.

Person-centred therapists also are committed to lifelong self-awareness and development. They seek to be non-defensive about their own limitations, even while they are open to the discovery of clients’ undiscovered possibilities. Person-centred supervision focuses as much on the therapist’s state of mind as on the client’s (Lambers 2006). John Keith Wood (2008) described Carl Rogers in several settings, then observed:

Although his apparent reaction, his manner of expression, his feelings and circumstances may have been different in each of these situations, I believe Rogers approached them in the very same way. He approached each situation with the same desire to understand, the same good humor, the same humility, the same honesty, the same non-judgmental acceptance of the individual or the group, the same curiosity and openness to learning, the same will to facilitate a constructive outcome for the individual or group. He improvised from his knowledge and abilities in each specific case. (2008: 20)

As a person-centred couple and family therapist, there is always more than one voice in my head. Like Peter Rober (2008), I am my experiencing self, with my own emotional and intellectual reactions, meeting with other people; as well as my professional self, responsible for choices based on my training and the expectations of the clients. I am always in a brand new, never-before-known meeting with clients and am, as well, the carrier of the practical, theoretical and research findings of systems therapy. The person-centred approach has been described in many of Rogers’ works (particularly 1961, 1980; Kirschenbaum and Henderson 1989, 1990) and interpreted and expanded in the work of Mearns and Thorne (2000, 2007), Barrett-Lennard (1998) and most recently Cooper et al. (2007, forthcoming). Here are four elements of the person-centred approach that I carry with me:

- **Self-concept and the ideal self.** Therapists are sensitive to the difference between self-concept, a picture of self that clients experience and evaluate, and ideal self, a picture of self living up to the expectations of self and others, as it shows itself in fear, doubt and frustration in individuals as well as the whole group. Person-centred empathy facilitates clients’ awareness of expectations that drain confidence and fuel frustration. One outcome of relationship therapy may be a client saying something like: ‘If I focus on who we are,
Challenges of Person-Centred Relationship Therapy

I relax; if I think about the marriage I expected to have, I get tense.’ The self-concept of each individual attracts therapist attention and care, even while they attempt to understand and facilitate dialogue about interpersonal concerns and possibility. The congruence between self-concept and ideal self in any individual at any age affects the self-concept of the entire family. In couple and family therapy, clients often see a change in a loved one’s self-concept as a threat to their own. In a couple, when one person becomes more independent it can seem that the other is less important. In a family, a new close relationship can make it seem that a child or a parent is no longer important. Chapter 3 on systems thinking will discuss the seesaw-like effect of change among intimates.

- Clients experience themselves as in charge of the therapy. The therapist may offer suggestions, structures, comments and perspective, but only what has resonance or meaning for the clients is a lasting focus. Rogers described the locus (place) of evaluation that resides in the client rather than the therapist (1959). This concept is similar to the Bowen systems idea of differentiation (Friedman 1991). It refers to the ability of clients to separate their own feelings and intentions from those they have absorbed from others. The more the clients feel that their own judgements are attended to and trusted, the more they take effective control of their own lives. A person-centred approach encourages a higher trust in clients’ own perspective and a lessening of attention to ‘shoulds’ imposed from outside. In a summary of years of research about clients’ experience of therapy, John McLeod (2006) asserted: ‘Clients consider themselves the producers of their own treatment.’ They also ‘have countless more thoughts than they tell their therapists’. Being client-centred is not the absence of therapist power; it is the presence of attention to client power. A person-centred relationship therapist facilitates clients’ ability to talk about differences without having to blame or reject.

- Actualizing tendency. Therapeutic practice revolves around the concept of the ‘actualizing tendency’ or ‘innate capacity for human beings to move toward fulfillment of their potential’ (Mearns and Thorne 1988). The perception that all clients’ words and actions are, in some way, clients’ attempts to become their fullest selves can be a powerful ally in sorting out couples and families in distress. Listening, attempting to understand and attempting to make sense out of seemingly impossible predicaments all derive power from the integration of this core concept. Person-centred supervision – actually, any helpful
supervision I have ever had – finds its centre in the trust of that in clients that is trying to survive and grow. This core principle of the person-centred approach is compatible with the family therapy tradition of reframing, ‘offering a different perspective which changes the meaning of an event or process (usually but not always in more positive terms)’ (O’Leary 1999: 36) and ‘emphasis on the positive’ (Hoffman 1998). Without neglecting the expectation that problems will be addressed if not resolved, person-centred therapists prioritize finding the family’s best intentions rather than fixing their perceived deficiencies.

- *Evaluative tendency.* Therapists hold the belief that ‘the evaluative tendency’, judgements of others’ actions and words, causes many if not most human relationship problems (Rogers 1961). In this, they may parallel narrative therapists, who seek to redefine relationship troubles as processes that oppress all involved rather than the product of one person’s bad intentions or lack of competence. The therapist can never do away with the tendency to judge, but can listen for alternative ways of understanding that which is judged. Clients, of course, bring many judgements of one another into every session. The therapist does not argue with or blame clients for these judgements, but focuses on the wishes and intentions behind them. At best, all clients find themselves in an ‘error-friendly zone’ (Lambers 2006). Their efforts and intentions are more important than their perceived shortcomings. The work of empathy is, in part, about making room for co-existing good intentions in the presence of complicated predicaments. Therapists accept clients exactly as they are in the situation they are in and facilitate that acceptance in client relationships. Insofar as a person becomes expert in the person-centred approach, they develop a facility, not of showing clients what is right but in relating so that clients feel less in the wrong.

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**Case Example 1.1: Family Therapy Walks in the Door**

This case illustrates the practice of multi-directional partiality, knowledge of the way developmental change appears in the form of trouble and active facilitation through a crisis to higher level of organization. I will also show the importance of readiness to see how development (e.g. a child becoming an almost-adult) changes a system’s functioning
The case also illustrates a simple kind of choreography that allows people to have strong feelings without victimizing a loved one.

Peter was not, as scheduled, in the waiting room alone: he was accompanied by his wife, Linda, and their 15-year-old son, Josh. Linda and Josh, sitting as far away from Peter as the physics of the room allowed, looked as grim as Peter looked angry. Linda had insisted that all come in for Peter’s appointment because of a scene between Peter and Josh just before it was time to leave for my office. Peter had lashed out at his son, who, because of a painfully intrusive disorder, with physical as well as psychological symptoms, has usually been treated with loving, permissive, almost unlimited attention.

In my office, with Peter glaring at her and Josh sitting close to her, Linda began to talk.

**LINDA:** I heard Peter saying terrible things to Josh and I said, ‘We’ve got to resolve this tonight. We’re all going in to see Charles.’

**THERAPIST:** It’s an emergency. We’ve got to bring this into the therapy. Something has to stop. *(The therapist empathizes with the individual. Claiming the right to do that, in itself, slows down the family process.)*

**LINDA:** Exactly. I mean, Josh isn’t perfect but Peter’s supposed to be the grown-up and what kind of example is he setting with the things he said?

**THERAPIST:** So, Peter, you agreed to have Linda and Josh come with you although all of you are angry and upset. *(The therapist continues to slow down the process and explicitly reflects a shared state of mind as well as purposeful action in the face of angry conflict.)*

**PETER** (with some bitterness): I didn’t have much choice, but this is fine. It all needs to come out. We’re both supposed to bend over backwards for him [Josh] but we are never supposed to ask anything of him. Well, it’s got to stop!

**THERAPIST:** You’re so frustrated right now. It’s as though you’ve got to change everything about how the family does things. You want it known that Josh and Linda can’t expect so much of you. *(The therapist both empathizes with Peter’s feelings as well as acknowledging the possibility of an important communication about change in the midst of a seemingly directionless fight.)*

**PETER:** I’ve had it. (To Josh) You don’t do a damn thing to help yourself. So we have to treat you with kid gloves!
THERAPIST: (drawing the angry force away from Josh) You are really feeling it’s not fair. You feel overwhelmed about what Josh seems to expect of you.

PETER: Well, it’s all got to change. We have to be perfect. He can have and do anything he wants!

The therapist is drawing on the concept of choreography brought into family therapy from psychodrama by Virginia Satir and Peggy Papp, among others (Papp 1983). The therapist allows Peter to speak angrily to him about feelings, while the original object of the feelings can observe them rather than take their emotional force directly. Peter’s (or any person’s) need to vent does not mean another family member has to absorb his angry energy.

The therapist continues to reflect Peter’s expressions as feelings Peter has rather than factual or authoritative statements about Josh. He is both responding to Peter and adding the dimension of context to the dialogue. The fight that the family brought into the room gradually is translated into Peter’s legitimate expression of feelings.

PETER: And it’s time you grew up. You don’t bother to work on your own problems! So we have to drop everything to help you twenty-four hours a day. I am sick of it and sick of you.

THERAPIST: You’ve really got to get this across. You are afraid that Josh doesn’t understand that you need things to change. Josh, what do you think of what your father is saying?

Most of the time, in fact, Peter was loving and very available to his son, but he had also long complained that his son would do anything to prevent his saying no or withdrawing when he had nothing to give. When tired or not feeling well and blamed by Josh by not helping him, Peter would sometimes turn from loving attention to furious blaming. Linda found it easier to meet Josh’s demands, but was quick to anger at any signs of her husband withdrawing from or blaming their son. Josh, usually good-natured and loving to his parents, could also become furious and profane when frustrated or left to his own resources.

Peter’s individual frustration has as large an impact on Josh and Linda as their reaction has on him. Part of the process of the therapy that evening and in other meetings was to pay attention to the way change in Peter would affect his wife and son. We also discussed how
Peter might be expressing a change in the family development in which more responsibility would be handed over to Josh. A family crisis, however ungraceful, can be an attempt to open a door to change. Peter’s need for change in the way the family members supported each other had validity; it was also true that he received much support during crises with his own health problems that he was not acknowledging in his current, emotionally aroused state. In this situation, as in many others, the therapist is aware that the conditions Peter is protesting were co-created and maintained by his own words and actions. Concepts from structural family therapy (Minuchin 1974, to be described in Chapter 3) help the empathic therapist: he is aware that a transition usually takes place when a child reaches Josh’s age. Often first signalled by a fight, the transfer of responsibility and eventually authority must take place between parents and child. This awareness, while not expressed, allows the therapist to have confidence that a family, though in distress, is moving an important direction.

Eventually, the therapist spent five minutes alone with each family member to give them an opportunity to be heard without setting the others off. (This is one of many ways in which a therapist may facilitate a transition between intense interaction and individual reflection and integration.) The family then reconvened for calmer talk, in which Peter continued to insist that the family needed to change but with less accusation. Josh was given an opportunity to speak, which revealed more about his feelings of responsibility to help his parents with their marriage. Linda conceded Peter’s right to say no to Josh, but also said that Peter as well as Josh expects her always to say yes, which she almost always does. She was also able to express her own grievance at not being able to come home from her difficult job without running into a fight.

In this case, the family members were able to express their individual frustrations in a setting in which feelings were allowed but not treated as objective facts with which to shame other family members. In the individual appointment that followed this session, Peter reported that each person felt heard and no longer under attack. In helpful dialogue, individual perceptions can be allowed to emerge side by side rather than in opposition to each other (Senge 1990). Furthermore, the expression of emotion in a safe, empathic setting allows for individual issues to be acknowledged and a new stage in family development to be named. Among new patterns emerging were the following:
Family therapy in which a therapist translates individual client feelings and thoughts allows a fight to become a dialogue and opens up the possibility of a higher level of family functioning. A family therapist’s goal of facilitating transition from one stage to another is enhanced by a person-centred interest in hearing everyone out.

Conclusion

Chapter 1 has focused on the challenges all relationship therapists face, which lend themselves to a person-centred approach integrated with many resources from varied systems therapy traditions. Therapists must pay attention to clients’ unique goals while offering multi-directional empathy, understanding of the ways couple and family processes interact with individual perception and a willingness to facilitate the process actively. Centred on Carl Rogers’ core conditions for effective therapy, a person-centred approach suggests a life-long commitment to a ‘way of being’ (Rogers 1980) that can be integrated with the skills and knowledge required by couple and family therapy. Each therapist must find a way for the client experience of empathy and acceptance to appear in the midst of vigorous dialogue under stress. Chapter 2 continues the reflection on the integration of therapists’ personal attitudes with client-centred skills with a description of six practices of a relationship therapist.
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