The Person-Centered Journal

An International Journal Published by the Association for the Development of The Person-Centered Approach

ADPCA

Volume 25 (1-2) 2020

Policy Statement

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Internet Address
www.adpca.org/Journal/journalindex.htm

The Person-Centered Journal

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THE PERSON-CENTERED JOURNAL

The Official Journal of the Association for the Development of the Person-Centered Approach

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Editorial

Jo Cohen
Kutztown University, Pennsylvania

For the past 35 years, the ADPCA has served and supported the development of client-centered therapy and the person-centered approach through several channels, including an annual meeting, a website, the *Renaissance* newsletter, *The Person-Centered Journal*, a business and a discussion listserv, a Facebook group, and funding for CCT/PCA research and archive projects.

The ADPCA is a platform and milieu for exploring Carl Rogers' (1957) well-known conditions of therapeutic personality change--including, empathy, genuineness, and unconditional positive regard--, and his lesser-known conditions of client vulnerability, psychological contact, and perception of the conditions. In applying the core conditions to life, infinite reward is gained from their robustness. By living the conditions, we create a climate in which we may facilitate forward movement of organismic valuing tendency and self-actualization.

The current volume of *The Person-Centered Journal* represents a broad spectrum of client-centered and person-centered discoveries and applications. I am pleased to introduce the authors and their work, beginning with Issue 1, which opens with Peggy Natiello discussing becoming a client-centered therapist, with "twists and turns" and an "exhilarating sense of wonderment that comes from letting go of the expert role…" (Natiello, 2020, this issue p. 4). Following Natiello, Art Bohart shares his journey becoming an integrative therapist, taken from his presentation at the ADPCA conference in Chicago, in 2017. Next, Matthew Bolton articulates person-centered mentorship from the perspectives of both Carl Rogers and Fred Rogers; followed by a discourse on person-centered supervision by David Myers. After this, Amanda McGarry considers whether additional propositions are necessary in order for the self-actualizing theory to account for suicidal behavior. Finally, Issue 1 concludes with Emily Myers' report on benefits of attending an ADPCA conference for a student who is more oriented toward hard science, and a book review by Marge Witty.

Issue 2 of this volume opens with Lauren Moss and Helen Hamlet elaborating on the foundations of child-centered play therapy from their presentations at ADPCA 2019 in Kutztown. Next, Christine Storch presents transcripts of child-centered sand tray play therapy taken from a graduate course in play therapy. Following this, David Myers presents data from Carl

Rogers' actual self-disclosures in sessions. Then, Jody Long, Karen Aul, Susan Motts and J. Stephen Gufffey address the application of CCT/PCA principles by physical therapy students. After Long et al., Anastasia Joswick discusses how self-development theory and the 19 propositions connect to LGBTQ affirmative practice. Matthew J. Bolton, H. Michael Mogil and Alan E. Stewart then share their work on integrating CCT/PCA principles to help understand individuals' relationships and concerns with climate. The last article in Issue 2, by me, Scott Tracy, Felishatee Rodriguez and Ryan Bowers, explores counseling students' observations of client-centered behaviors in Alcoholics Anonymous groups.

I am thankful to Associate Editor, Marge Witty for providing essential leadership, transitioning, recruiting, and follow-up for this project. Marge also wrote the review of Brian Levitt's provocative book, *Questioning Psychology*, for this volume.

Finally, I am tremendously grateful for graduate assistant Crystal Santa's work as Layout Editor for the journal, and for support from the Department of Counselor Education and Student Affairs at Kutztown University.

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Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. The Journal of Consulting Psychology, *21*(2), 95-103. https://www.semanticscholar.org/paper/The-necessary-and-sufficient-conditions-of-change.-Rogers/be0c5e70f4c17f12252071a61ae038bb1edcb13d (then click onto View PDF).

On Becoming A Therapist

Peggy Natiello[1]
Sedona, AZ

"It is a miracle that curiosity survives formal education" Albert Einstein

Introduction

The healing in client-centered therapy, according to Dr. Carl Rogers, is in direct proportion to the *quality* of the relationship between therapist and client. An academic grounding in client-centered therapy is essential for the solid preparation of client-centered therapists. The theory of the approach is grasped easily; the translation of theory to practice, however, tends often to be problematic and oversimplified. It is the *quality and integrity* of the therapeutic relationship, the therapist's *capacity* to offer empathy, congruence, and positive regard to the client, and the *unquestioned authority* of the client that hold the promise of profound and unpredictable healing. The *practice* phase, (a lifetime undertaking), is more demanding and more radical than the academic phase.

Brian Thorne described the qualities of a mature person-centered therapist eloquently in his book, *The Mystic Power of Person-Centred Therapy* (2002).

> In essence, Rogers repeatedly affirms… it is who the therapist is, how fully he or she can invest himself or herself in the moment and how secure he is in his own being that matters. Such security does not imply invulnerability. On the contrary, to be accessible to another, it is important to acknowledge imperfection and flaws, and Rogers goes so far as to say that the very ability to help at all depends on such an acknowledgement. He goes on to speak of relationship where a level of such intimacy and intensity is reached that he feels his simple presence is healing. He concludes that it is the state of his own being in such instances that immense energy is released which flows from him to the client. …Rogers goes further. He claims unambiguously that there are times that 'the best of therapy…leads to a dimension that is spiritual' (Baldwin, 2000:35). At such times there comes a meeting of inner spirit with inner spirit and the experience of being part of 'something larger'. (p. 56)

[1] Peggy Natiello is a psychotherapist in Sedona, AZ and is a member of the Going Global staff. Peggy can be contacted at ranacom2@gmail.com.

In the interest of illuminating some of the promise and complication of client-centered practice, I offer a few examples from my 40 years of practicing as a client-centered therapist and guide. These interactions are among the many that took an unpredictable turn and will, hopefully, encourage therapists with less experience to welcome the exhilarating sense of wonderment that comes from letting go of the expert role and allowing the client to lead the way. Whereas some sessions with clients unfold predictably, the examples below reveal the surprises and learnings that can spring up if therapists can allow for the unexpected. The sessions occurred over a ten year period and were written up immediately following their closure.

Edith

Edith came this morning. The social worker who was working with her at the nearby hospital where she was treated had called to apprise me of two serious diagnoses. I quickly set them aside as I prefer not to use diagnoses when getting to know clients. By the end of our hour together, she insisted that I was the only person she had met that she felt comfortable working with.

The beginning was somewhat difficult. For the preceding six months Edith's psychiatrist had medicated her heavily, and she felt miserably unlike herself. She confided that she had fallen periodically into depressive episodes and developed "Restless Leg Syndrome" – both of which she attributed to psychiatric medications. "I do not feel like myself, cannot control the movements of my legs, can't sleep at night, and I know it is the meds."

One day she came for her session and told me she had gone off her meds – cold turkey. A Native American Medecine man, who she knew well, had called to tell her he had some special medicine he had obtained from out of state, and he wanted her to try it. When she came to the next session, she had already decided to take this instead of the prescribed medicines the psychiatrist had given her, and she had removed herself from his care. She would, she said, understand if I refused to continue seeing her, but she wanted to be honest with me. (I knew the herbs were medicinal doses of Peyote, because she had shared with me her strong beliefs in Native American spirituality and her membership in one of their churches. Peyote is an illegal drug, although the native people have permission to use it for their ceremonies.)

My experience had consistently taught me that, if patients resist the medicine they are given, it probably would not be helpful. On the contrary, those who followed personal beliefs about wellness, were much more likely

to be healed. I decided to trust my intuition and continue seeing her, although my 'academic learning' was challenged.

From that time, with diminishing doses of peyote, I watched her return to health…no more restless leg syndrome, no more dry mouth and slurred speech, fewer feelings of powerlessness, fewer sleepless nights. She eventually gathered the confidence to accept a part time position in the educational field, and continued to move into roles of growing responsibility.

Still, Edith was sometimes overwhelmed by pressures in her life, and feelings of personal inadequacy. She told me she often "ran away" from home where she cared for her husband and daughters.

"What does that look like – running away?" I asked curiously.

"I get in the car, go to a neighboring town, sometimes rent a motel room, drink coffee, smoke cigarettes, and go to movies," she admitted with obvious humiliation and shame.

"Gosh, that sounds to me more like taking a break than running away," I responded. She was obviously shocked at my reaction and surprised that I did not condemn her. Every time she "ran away" from that time onward, however, I listened quietly. The story was always the same. The stress of her life sometimes became unbearable. I continued to hear and speak about her 'outing' as a 'break'. At the end of our session last week she left in tears, mostly around feeling trapped in her house with all her responsibilities. A few hours later, her husband called, asking anxiously, "Peggy, do you know where Edith is?"

"No, Joe, I don't. She was a little upset when she left, and she might just be taking a bit of a break. Maybe she's sitting in a park somewhere. I wouldn't worry about her though. I am sure she is alright."

I actually had no concerns at all (due to my experience with her), and trusted that she was going to take care of herself. When she came in a week later, I mentioned Joe's call and asked where she had been. "Oh, I didn't know he called. I went to a movie," she said. "I decided I needed a little space and took a break." There was no hint of judgment or shame in her voice or attitude, as there had not been in mine. I knew the healing was progressing just the way it should, and that this client's actualizing tendency was in full swing. She was claiming the right to be the ultimate authority in her life, and there was no cause to question her.

Rebecca

Today Rebecca came in for an interview session. She was a patient of, and referred by, my physician. A very attractive woman, she did not

seem to carry the 60 years she claimed as her age. She spoke quietly, without affect, about parts of her life including marriage to an older man – a marriage in which she did not feel like much of a person, and had recently dissolved. A new primary partner, John, had recently moved into her home to be with her.

I found it difficult to engage with her because of her lack of affect. There was very little feeling in her voice, even when she said that her new partner had recently taken his own life. I, however, was stunned into attention and moved to the edge of my chair.

In the same toneless voice, she said, "I haven't had a visitation." I asked her what she meant by 'a visitation'. She responded, "Like an appearance of him standing beside my bed." I replied that 'a visitation' does not always come in that form, but sometimes in an event in nature, or a melody floating in the air, or a startlingly brilliant memory. We spoke about grief. She asked me how to "do grief." I responded that I had no recipe but perhaps to let it come, if it announced itself. I now understood the absence of feeling in her voice. She was in shock.

Rebecca was sitting in front of one window of a 3 section bay window in my office. Three large windows revealing the red rock view behind our house, looked out onto a patio surrounded by an adobe wall. As Rebecca droned on about her partner, John, I became aware of what looked like a bird resting on a wooden slat outside the window behind her, veiled by the opaque shade partially drawn. I rarely interrupt a session, but surprised myself by saying," Oh, there's a bird outside behind your back. It must be a Quail." She did not respond, nor did she look behind her. I tried to bite my tongue (to no avail) when I realized that the feathers seemed to be black. (Quail are a soft café au lait color.) "Oh, that's NOT a Quail," I muttered, astonished at my second intrusion. Suddenly the feathered creature disappeared from behind her and jumped to the patio floor in front of the unshaded middle window. "Oh my God," I exclaimed! That's a Road Runner! I have never seen one here before."

The bird stood still in the patio, right outside the window. Road Runners are quite tall, with long elegant necks and spikey tails that stand out stiffly behind them. This bird fixed his eyes on the client for a long moment, then turned and walked slowly to another section of the patio. (Road Runners rarely walk slowly as their name would imply.)

Now the client gasped, and said softly, "John was a Marine, and had a huge tattoo on his left arm that went from his shoulder to his elbow. The tattoo was a Road Runner."

My entire body knew that this was not a mere coincidence. Even my fixation on the bird had seemed beyond my control. "Rebecca," I said reverently, "I think you are having a 'visitation.'"

Her head dropped; she was absolutely silent; finally, the sobs came tumbling out. She only allowed herself a few minutes of unaccustomed grief before she snapped her head back and said, "That's enough." Her face and her body had softened, and she said quietly, "I feel much lighter", tapping her heart gently with the palm of her hand. The bird hopped over to the window again, gave a final long look her way, and then disappeared.

I knew this was an other-worldly event. It had demanded my attention in defiance of what I believed about giving the client undivided focus. It filled my heart to the brim, and spoke unmistakably to her. The specific lesson for me: Be fully present, and make sure the climate of your meeting is filled with genuineness, empathy and positive regard. Have no agenda. Don't waste time figuring out what you can do to help or fix this person. Be fully tuned into yourself and to the client. Simply dwell there with humility, deep caring, and faith. Accept the uncertainty and the experience of the client. Everything you both need for the work to unfold is there and will eventually reveal itself.

Maureen

I opened the door in response to Maureen's knocking. A quick scan of the outdoors revealed that she had left her car in the middle of the street, motor running and turn signals blinking. I asked her to move the car into our driveway, even though she appeared to be on the verge of collapse.

After she had parked her car, Maureen fell into the office chair. "I've been in bed since last Wednesday. I've called my place of work and cancelled every day since then. I think I'm having a breakdown!"

We had our first meeting exactly a week before, and I knew that she was in a crisis-ridden period after having recently survived an only son's drug addiction, a difficult divorce, an extreme drop in income, and a long distance move. Together with her desolate childhood story, shared the previous week, her feelings of exhaustion and lack of control seemed perfectly justifiable.

But that was not all. That morning, she reported, the Drug Enforcement Agency (DEA) had called her from the state of Virginia, to tell her that Customs had confiscated an order for diet pills she had placed online. They claimed it contained some cocaine, and that she had a date for a court appearance in Phoenix, AZ. The caller provided her with a case

number, and when she blurted out a denial, he said he would try to help by negotiating with a Customs official. After a short delay, he returned to the phone.

"Good News!", he cried out, "they have agreed that you can simply settle a fine, since you seem to have no previous record, and they will waive the court date."

"What is the fine," she asked, and began to cry upon hearing that it was $3500.

The story unfolded. He got her a 'great deal' by putting her in the 'Gateway Program', and that cut the fine down to $1500. When she said she could not come up with that money for a while, he told her she needed to have $750 of it, in cash, by 1pm the same day. As she poured out her story, shaking and crying, it became more and more clear that this was a scam, a hoax, but she was too vulnerable to see that.

She talked about her easy relationship with 'victimhood'. "It's easy for me to be the victim," she told me, "and I hate it!" I suggested that, this time, she could become a public advocate, a heroine, instead of a victim, if she chose to report the incident. Her face lit up, and she said she thought she could do that. I dialed the local Police Station, as a first step and handed her the phone. She told her story. They sent her forward by giving her the name and phone number of the State Attorney General. She left him a message while still in my office, promising to follow up on the call.

Later that afternoon the phone rang and it was Maureen. She wanted to give me an update. She had called The Drug Enforcement Agency in Washington, DC, and they were already on the trail of the perpetrators from Virginia. There had been a number of reports of the hoax and they were closing in on the group perpetuating the 'crime'.

"Congratulations!," I said, "you are not a victim, but a public advocate! And you sound much different than you did this morning."

"Oh, my God! I feel like a completely different person – very empowered and not at all like a victim. Thank you for helping me find the courage I didn't know I had!"

It is rare for me to give a client a suggestion, so in some way I broke my own rule. But I could see that she was feeling powerless, and that a nudge from a trusted ally might help her break through her powerlessness. My hunch was right, as hunches often are. They come out of the intuitive understanding we work so hard to acquire…sometimes called empathy.

Peter

Recently returned from a 6-day global meeting in Vermont, I had dreams of crashing for a few days. It was Saturday and the weekend stretched ahead of me with promise of open-endedness and luxurious rest. When I picked up the ringing phone and heard a stammering voice asking me for a Sunday appointment, I flirted with refusing. The urgency in the voice of a man at the other end of the phone, however, persuaded me to set up an appointment – Sunday be damned!

My husband and I were negotiating with a solar installer when I saw the car pull up. I suggested they be sensitive about trying to engage him, as this client's stammer suggested intense anxiety. He passed by them without interruption, and I led him into my office. Immediately apparent was his unusual height (6ft.7in). In addition, he was excessively thin, quite good looking, and probably in his early 40's. In our initial conversation, I found him to be articulate, bright, and self-aware. Very quickly, however, his body and voice began to shake and he admitted to being severely depressed, suffering panic attacks, and close to the end of his rope. It was clear that he was unraveling in front of me. The stammer transformed into an unmanageable stutter. He had to hug his chest area with both arms to control the shaking, and several times his legs gave way beneath him, his long frame crumpling onto the floor. At one point, he fell asleep. I let him alone.

His name was Peter. His story one of childhood desperation …… an authoritarian heartless father, a beloved mother who died when he was just a child, a sense of being a burden and never measuring up. Now his father had passed away, and he had no idea how to take care of himself. He was terrified!

He found a placed to stay near our home and we began to work together, often. Gradually he gained self-confidence, got a good job with the Forest Service which included housing, and took off into a hopeful future. Our non-traditional relationship broke some of the rules of the therapeutic encounter, but I chose to trust its integrity and congruence. I responded from my heart rather than my head, and he kept in touch with me for years, always verifying the value and depth of our relationship.

Isaac

An elderly gentleman found his way into my practice. He was drawn to me because of my 'high spirit', he said, and he wanted to know my secret. He had been a Broadway Producer in his prime but now was quite fragile physically. One morning, shortly after we began our therapeutic relationship he stumbled into the front door muttering that he had just seen his cardiologist and "He told me I could drop dead in a minute – anywhere, anytime. I have congestive heart failure."

I had to support him walking to the office as he was very unsteady on his feet. We passed our dining room where we had entertained dinner guests the previous evening, and the table was not completely cleared. Upon taking his seat in the office, he said, "I see you had wine last night. I used to love wine with dinner. What kind did you have?" Somewhat taken aback, I told him what kind of wine we had served. He asked if he could have a taste. "Isaac," I replied with an edge of irritation, "you have just told me you could drop dead any minute and now you are asking me for wine? And in the middle of the morning!" "Just a taste," he responded meekly.

We proceeded with our session, and I began questioning my response…silently but with great discomfort. What was I doing? Why? What was wrong with Isaac asking for a taste of wine? Why was I assuming the authority to say "No", and taking on the expert role with my client?

I asked to be excused for a minute; went to the kitchen and asked my husband to get a crystal wine glass from a high cupboard. I poured a small portion of white wine into the glass, returned to the office, and put it on the table in front of him. He looked surprised, picked up the glass, and took a little sip. "Very good!," he pronounced, and drank no more.

When the session was over, he got up, and thanked me for the insights – and for the sip of wine "in such a lovely glass."

Isaac passed away within a few months, but not from the sip of wine! I am so grateful still that I could hold the 'double vision' that I think is important in client-centered therapy. I could f*eel* my own reaction to his request and could see my discomfort while hearing his plea. Being congruent and self aware saved me from 'pretending' for the rest of the session …..pretending to be empathic when I was irritated. I have often wondered why he asked for the wine. I suspect he was testing my caring for him, but it doesn't matter. What mattered was that I was able to throw away the academic rule book, evaluate my reaction, and give a person I cared for deeply the human responsiveness he obviously wanted – and deserved.

Tim

Upon opening the office door, I met Tim, a young marine lieutenant, small of stature, handsome, dressed in an immaculate uniform. Exceptionally polite and deferential, he addressed me as 'Maam', and yet I felt nervous and intimidated throughout the session. I was puzzled at the feeling, but it was strong……so much so that, before the start of the 2nd session, I programmed my office phone with the police phone #. One push of a button would contact them.

As the session unfolded, Tim shared some horrific stories about his childhood. He had a very cruel stepmother who, among other violations of his humanity, would hang him from the meat hooks in his father's butcher shop when he did anything that incurred her disapproval. As the tales of her abuse tumbled out, I realized that he was full of rage although he presented himself as if everything was 'buttoned up'. Clearly my discomfort was set off by the incongruence between his polished appearance and the depth of hurt and anger that lay close to the surface. As soon as I realized this, I felt a *rush* of relief…all my anxiety disappeared.

"What just happened here?" he asked. "Everything in the room has changed!" I knew absolutely that he had picked up on the radical shift in my attitude. He had intuited something about me just as I had sensed his unexpressed rage. I wondered how to respond. Then I recalled Carl Rogers saying (often), "The facts are friendly" and I decided to reveal the facts of my own experience. When I finished sharing what had happened to me, Tim's whole body relaxed and he thanked me for confirming his intuition.

This incident was a powerful learning about congruence. If therapists have strong feelings or intense reactions in a session, they generally need to share them. Otherwise the offering of empathy or unconditional positive regard is inauthentic and manipulative. Clients will generally 'feel' the incongruence, and that can lead to a serious breach of trust. I have had this experience enough times that I know when it is interfering with the climate. Watch out for it!

Joan

She was an exceptionally gifted client on the east coast. A dual profession creates a glimpse into her multi-talents – musician and attorney. Her presenting issue was depression. She had struggled with it all her life, and had attempted suicide at least twice. Her wit, her darkness, and her intelligence moved me immediately and our relationship was easily cemented.

One day she came and told me she felt outsmarted by life, was tired of it all, and had purchased a gun so she would have a way out of this world if she needed it. Our very close connection led to a certainty that she had the gun on her person. "Would you like me to hold the gun for you," I asked quietly.

After a long moment of silence, she reached into an inside pocket of her brown suede jacket and pulled out a small gun. She turned it over and over in her hand before she said, "If I ask for it back, will you give it to me?"

Another long silence while I carefully considered her question. What would I do if she asked for it, and I knew she was depressed? How could I turn it over to her? How could I lie about this decision? How could I betray her? I decided that I could and would return the gun if she asked, and told her so.

She took a tissue from the box on my desk and carefully removed the bullets from the gun. After placing the bullets into her purse, she handed me the gun with eyes averted. I had never held a gun before, and its cold hardness chilled me.

When she left, I pulled a large coffee maker from the closet. It was white plastic and had a canister for the water in which I placed the gun. Nobody could see inside the canister if they stumbled on it. I put it in the back of the closet, and it remained there for about 8 months while we continued to work together.

One day Joan came in, and, after some small talk, asked me for the gun. "Don't worry, Peggy", she said softly. "I am asking for it so I can get rid of it – not to hurt myself." I pulled the coffee maker from the closet, and gave her the gun…and a long hug. She thanked me, and I knew we both had done the right thing.

Where does that knowing come from? It emerges from the deep commitment to another person; from the kind of listening that helps the therapist and client merge; from the congruence and honesty that marks such a relationship; from the acceptance that the client is the best expert on her or his life, and can be trusted to make the right decisions.

Janine

After three weeks of false starts in setting up an initial therapy session, the doorbell rang on a Friday morning. On the stoop stood a very short, middle-aged woman with unkempt brassy-gold long hair. She wore a chartreuse, bouffant, floor-length skirt, knotted in several places around the hemline to prevent her from tripping. The laced opening of her white embroidered peasant shirt revealed some cleavage. A quivering, hesitant smile, and furtive eyes seemed to communicate fear – or at least anxiety. Warmth and curiosity seeped into my awareness, and I felt the openness of my heart.

Her feet dangled above the floor as she settled into the leather lounge chair in my office. Her eyes darted around the room and she pulled nervously at her purse and skirt, while I waited quietly for her to begin. The story that eventually unfolded was one of severe childhood abuse resulting, she said, in dissociative (her word) behavior. She described an inability to

trust almost anyone; a harrowing fear of death; low self-esteem; and recurring symptoms of PTSD. She disclosed some contempt for therapists and therapy, and gleefully shared her propensity to play intellectual games with the ones she had seen over the years as a strategy to avoid emotional depth or connection. I listened, nodding but saying little. A half hour into the meeting, she suddenly blurted out, "Oh, I cannot believe this! I really like you!" and burst into tears.

I have been doing this kind of work for years, and often have to fight off a twinge of anxiety when meeting a new client. "What will this person present? Will I be up to the job? Will we feel reasonably comfortable with each other?" This particular encounter was devoid of any such concerns. I was utterly without agenda, and open to hearing her distrust of therapists or anything else she chose to share. I felt like a seasoned client-centered therapist – through and through.

How does this happen? Graduate students ask this question often. It is, of course, a process, but it is a process that cannot be taught, it can only be learned. The learning occurs when the therapeutic relationship is grounded in person-centered values - a deep trust in each client's actualizing tendency, therapist courage to be authentically present, and the maturity to offer a climate pervaded with empathy, congruence and unconditional positive regard. With those values in place, one does not have to worry about the client. S//he will prosper and grow in such a climate, deepening their experience of self and moving forward in their healing. Confidence in the authority of the client and the client-centered process allows the therapist to let go of any agenda.

To underline the radical implications of that theoretical statement, I will cite one of my favorite quotes of Carl Rogers, PhD. It appears in *Client-Centered Therapy* (1951). It challenges the therapist's belief in the absolute authority of the client, and emphasizes the deep implications of the theory for the practice.

> ……when the counselor perceives and accepts the client as he is, when he lays aside all evaluation and enters into the perceptual frame of the client, he frees the client to explore his life and experience anew, frees him to perceive in that experience new meanings and new goals. But is the therapist willing to give the client full freedom as to outcomes? Is he genuinely willing for the client to organize and direct his life? Is he willing for him to choose goals that are social or antisocial, moral or immoral? If not, it seems doubtful that therapy will be a profound experience for the client. Even more difficult is he willing for the client to choose regression rather than growth and maturity? To choose neuroticism rather than

> mental health? To choose to reject rather than accept it? To choose death rather than life? To me it appears that only as the therapist is completely willing that *any* outcome, *any* direction, may be chosen – only then does he realize the vital strength of the capacity and potentiality of the individual for constructive action. It is as he is willing for death to be the choice, that life is chosen; for neuroticism to be the choice, that healthy normality is chosen. The more completely he acts upon his central hypothesis, the more convincing is the evidence that the hypothesis is correct (pp.48-49).

Conclusion

"*If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth and change, and personal development will occur"* (Rogers, 1961, p.33).

"Providing a certain kind of relationship" is the topic of this paper. It takes a look at how startling and unpredictable a direction 'this type of relationship' can take. It is a reminder that any person who sets out to be a client-centered or person-centered facilitator of growth will do well to spend a lifetime honing their capacity for the three conditions – genuineness, empathy and positive regard – as well as deepening their exquisite respect for the authority and personal power of the client/student/patient. It requires that facilitators abdicate all power-over, all expertness, all conviction of being the savior/problem-solver/hero of the work in which they are engaged. In other words, it calls for a deep engrained humility, a strong commitment to egalitarian power, a profound openness to and acceptance of the life and experience of 'the other', and an unwavering faith in the actualizing tendency.

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From Gendlin to Rogers to Brodley to Bohart: My Evolution as An Integrative Person-Centered Therapist.[1]

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I want to thank Marge Witty for my introduction, and I want to comment on her quoting the African proverb that I use to introduce a chapter by myself and Karen Tallman (Bohart & Tallman, 2010) on the role of the client in psychotherapy: "Until lions have their historians, all tales of hunting will glorify the hunter." That refers to the fact that in most stories about psychotherapy, the "hero" is the therapist who slays the monster of the client's problems (Duncan & Miller, 2000). What we argued was that research shows that it is actually clients who make therapy work. They are active self-healers who use therapy to make that happen. Therapists are more like their assistants. With that in mind, I want to mention that Karen Tallman, who's now my wife, does research for Kaiser medical foundation. She's planning to start doing a study. She wants to contact people who have type two diabetes who have successfully managed to self-regulate on their own so they don't have the disease anymore, and interview them about how they did it. What she is discovering as she's doing the literature review preparatory to proposing the study is that with all the research on diabetes– and you can imagine how much there is out there because it's such a horrible epidemic -- there's almost nothing on the patient. It's all on interventions that the medical community comes up with. It's like no one bothers to listen to the patient.

This talk is about my journey as a person-centered therapist. The first thing I want to bring up is, why should you care? My answer to that is that I don't have the faintest idea. I hope that what I say will reinforce what you already know or maybe help sharpen and deepen it. If you disagree, as I'm sure some of you will, I hope that will also help you sharpen your thoughts as well.

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[1] Based on an invited presentation at the annual conference of the Association for the Development of the Person-Centered Approach, Chicago, IL, 2017. I wish to thank Marge Witty, Susan Pildes, and Carolyn Schneider for inviting me to speak. I particularly want to thank Bruce Allen who transcribed this talk from a videotape. I then went through it and revised and edited it.
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The second thing I want to bring up is my debt to Eugene Gendlin, and I have organized the talk around that for that reason. Gendlin is the single most important person in my professional life. I would not be here were it not for Gendlin's work, and since he passed away a few months ago I wanted to honor him[3]. That doesn't mean I entirely agree with everything he did or said, but he had a huge impact on me as you'll see. Finally, some of this talk is based on an article I wrote a year or two ago, published in the *Journal of Clinical Psychology* "From There and Back Again" (Bohart, 2015).

So, to go back a little bit in time, it is now 1968. I'm a third-year graduate student. I've been doing therapy for two years. My clinical placement is at a school for kids with learning disabilities. At this point, my orientation is existential. I had started out as a graduate student as an existential psychoanalyst. I believed what I was supposed to do was to help the client get insight into their childhood, and to be more authentic. However, after two years of my own psychoanalysis, I had grown disillusioned with psychoanalysis. I learned a lot from it, in a funny kind of way, in a negative direction. I learned the utter impotence of intellectual insight, and because of that I dropped the psychoanalyst part, and in 1968 I was just an existentialist.

The problem was that there was no method to existential therapy, and I still felt I didn't know what I was doing. In terms of the client acting as a self-healer, it's really interesting because I didn't know what I was doing for two years, and my clients got better anyway. So, starting at this placement at the school, my supervisor was a Gestalt therapist and I got enamored of Gestalt. I was told that Gestalt was existentialism with a technology. Fritz Perls came and did a demonstration at UCLA. I was really impressed. It was in the days of hippies and he came out in front of this audience of psychiatrists and psychologists with bare feet in sandals, and with a piece of rope holding up his pants. I fell in love with Gestalt, but unfortunately it was more of a fling. It didn't turn into a long term relationship.

I became disillusioned with Gestalt for two reasons. One, it was too confrontational. The second reason is that it was self-contradictory. I was told that the goal was to help clients find their own paths. However, I had gone into Gestalt therapy myself, and, although I was told it would help me find my own path, I soon discovered, in one incident, that the therapist was

[3] Gendlin passed away on May 1, 2017.

the one who knew what my path was, and that didn't work for me. So, at that point, I was kind of lost as a therapist.

I was working with a ten-year-old boy doing existential and Gestalt and it wasn't working. I had to write a qualifying paper for my dissertation. I decided to do it on insight and interpretation in psychotherapy because I was interested in that topic. I got a book called *Use of Interpretation in Treatment* edited by Emanuel Hammer. It had an article by Gendlin in it called "The Experiential Response" (Gendlin, 1968). I had never heard of Gendlin before. I didn't know he was Client-Centered. I read it one night and it absolutely resonated. I mean it fit like a glove. The article did to me what Gendlin says good therapist responses do to people—they help you articulate what you already implicitly know in your body, and that's exactly what the article did to me. I went in the next day and worked with my ten year-old boy and applied Gendlin's method of responding to felt meaning. The session went much better. At the end of the session, my supervisor who had been watching through a one-way mirror, came out and said, "That's therapy! That's therapy!" The next week when the boy was brought in by his mother, the mother told me that he had been much better that week, and he continued to be much better thereafter.

What that demonstrated to me was the power of genuine, careful–and responsive–empathic listening, because that's what I thought Gendlin's method was all about. I thought what Gendlin had done was to specify what it was to empathically listen. Here was proof positive that just carefully and genuinely understanding someone could be really powerful. I had read Rogers and I had generally agreed with Rogers. All my experiences previously, my previous placements, were working with people labeled schizophrenic which led me to believe that the general ideas Rogers espoused were right. Being empathic and warm and caring and showing positive regard, being genuine and congruent were the attitudes needed to help people grow. But Rogers had never hit home to me because I couldn't figure out what to do when I was being warm and empathic. I had seen the videos and it seemed as if he was just saying back to the client what the client had already said, which, of course, is not true, as I later learned. My students see videos of Rogers and they think the same thing, until they try to learn careful empathic responding, and come to know better, as I did. So, at the time, I wasn't a Rogerian. Gendlin provided not only a method but a theory of why empathic responding was working, and I had had proof positive with this from working with this boy. I thought I had found a home.

What I thought Gendlin to be doing is the following. We know more in our bodies then we know in words. When we talk, we're putting that holistic understanding into words. Words point at what we know implicitly.

Words come from felt meanings and experiencing. By listening to the felt meanings, you are listening to where the client is coming from, what they're trying to say, what they're trying to get at, their gist, if you will. So I saw Gendlin as trying to develop a theory of what it is to really hear someone, to really understand them, to really try to get what they're trying to get at, and to respond to them from that. I discovered that Gendlin was a Client-Centered therapist (at the time). So I went back and read Rogers, and now Rogers made more sense to me. I watched Rogers and now I could see more of what he was doing. I decided I was a Rogerian.

I want to talk a little more about Gendlin's theory of experiencing. I eventually came to disagree with Gendlin about some things and I'll come to that later, but I still think his theory of experiencing is essentially right. Gendlin was talking about the idea that we know more in our bodies than we can say; that we think in some sense in our bodies as well as our minds. This has become a hot idea now in cognitive science, and there's a whole lot of talk about what they call "embodied cognition." Of course, Rogers had the same idea with the organismic valuing process.

Gendlin talked about how people change. He pointed out that other theories were really good at describing what was wrong with people, their personality structures, and things like that (for instance, dysfunctional cognitive schemas in cognitive therapy), but they didn't have a theory of how change happens. For Gendlin, change occurred by tuning into felt experiencing. Experiencing is primary. Thinking and emotion are secondary to how we experience the world. Rogers basically agreed with that. Therapy has to be experiential in some way or another for change to occur. It's not enough just to know something in your head.

This is actually an insight that all therapies have had going back to Freud. Freud knew that it wasn't good enough to explain things to people to have them change. Cognitive therapy–you may think that's not experiential but Aaron Beck in one article said you have to get it in your gut. He literally said that. Cognitive therapists talk about it in computer metaphors— about how cognition has to be hot and "on line" to change. So for them, too, change has to be experiential. So it's really an insight that all have had. The interesting thing is that modern psychodynamic theory is becoming heavily experiential. They've really moved to a more Person-Centered point of view in a lot of ways.

Gendlin went on to say that people have an intrinsic capacity to grow--in our ability to experience the world, to move to more complex and differentiated forms, to become more balanced and open to new ideas. These are more my words than his words—to take more aspects of our

experience into account, and to trust things that just bubble up. Carl Rogers was always talking about new ideas bubbling up. And this allows us to access new and better ways of being in the world intuitively and experientially. There's an intrinsic creative process. Therapy is intrinsically creative. This is one of the big differences between Person-Centered therapy and other approaches. Other approaches are reparative. Person-Centered therapists believe that by helping people grow forward that problems get resolved. To use a metaphor of the redwood trees that grow in the area where I live: You can cut a redwood tree down and look at its inner rings and you can see an injury in there that happened hundreds of years before, but the tree grew up and around it. So therapy is intrinsically creative and this is another example of an idea I got from Gendlin. Change occurs when the therapeutic interaction provides experiences that help the client carry forward their own experiencing.

He also talked about responding to feeling and this is another thing I learned. What it is to respond to feelings. Most Western psychologists think that to respond to feelings is to respond to emotions, but Gendlin said that was not true. Feelings are more than emotions. Western psychology typically splits the person into two things, cognition and emotion. By feelings, most Western psychologists mean emotions. Gendlin introduced the concept of felt meanings. He pointed out that we know things in our body–as I said–in this sort of implicit way. There are endless examples of feelings that are not emotions. So I'm going to talk about feelings for a moment—examples of feelings that are not emotions. Feeling cold is not an emotion. Feeling hot is not an emotion. Feeling sweaty is not an emotion. If you consider those, you get a feeling about what a feeling is. A feeling is a feeling—"feel-ing," a touching. Feel-ing is a way of knowing. It's not something inside you, it's transactional, something between you and yourself and between you and the world.

So there are endless examples of feelings that aren't emotions. Love and hatred are emotions. We can *feel* love and we can *feel* hatred. But we can also feel appreciated. We can feel listened to. We can feel ignored. We can feel alienated. We can feel competent and none of those are emotions. We can feel disembodied. We can feel stuck on a problem today. We can feel like having pizza for dinner. We can feel like someone doesn't like us, and I'll come back to that in a minute. We can feel like a failure. We can leave a room and come back in a room and feel like something's happened and we don't know what it is. I think a lot of people have had that experience. So coming back to the example that someone doesn't like me, I can definitely feel that someone doesn't like me, while thinking in my head I'm wrong and believing intellectually that they do like me. One more example. Einstein said he was following a feeling in developing relativity

theory and surely he wasn't saying he was following an emotion when he came to develop relativity theory. So what kind of feeling was he following? Some kind of intrinsic sense, or "feeling" of how something works. It wasn't in words or mathematical symbols yet. It was something he sensed, a direction he sensed. And that was what he was following. But it was a feeling in a different sense than an emotion.

Let me give you an example in a story about one of my clients. This has to do with feeling that someone doesn't like me. There are those who will tell you if you say 'I feel you don't like me,' "That's not a feeling! That's a thought or a belief!" They're wrong. I had a client who came to see me[4]. He was very depressed. He had been seen by a psychoanalyst. I don't know how he found his way to my door but the psychoanalysis wasn't working. So he told me a story, and the story was that he had started having the feeling that his wife didn't love him, but it didn't make sense to him because she certainly acted loving. They were making love and she was loving in other ways. She said she loved him. He was troubled enough to see this therapist, this psychoanalyst. The analyst had the wife come in. After the meeting, the psychoanalyst was convinced the wife loved the client. He concluded that the reason the client had this nagging feeling was that he couldn't accept his wife's love was because of his childhood. In fact, he did have a bad childhood. He had a mother who would have gotten the borderline personality diagnosis.

This is when he got depressed, after he had been told by the analyst that his belief that his wife didn't love him was a distorted perception based on his childhood. So he had come into therapy with one problem, which was this nagging feeling he didn't understand, and now he had two problems, which is now not only does he have that problem, but now he's all screwed up. So this is when he got depressed. Therapy wasn't helping, so somehow he wound up seeing me. A couple of months later a magical change appeared to take place. It had nothing to do with me. He came in. He just walked in different. He still looked sad but instead of looking haggard and beaten down, he walked in with strength in his walk. He sat down and told me his wife had left him. She had admitted she had been having an affair for over a year, and that she didn't love him. As devastating as that might have been, it actually made him feel better because at least he wasn't crazy. That's just an example of how you can feel something in your body; you can feel a meaning in your body, and it's not a thought; it's not a belief. His feeling she didn't love him had been right on. So if anybody tells you 'that's a thought or belief'—be aware that it may *not* be. It may be

[4] This case is disguised.

a "felt sense." By the way it was something like this that made me break up with my Gestalt therapist. I said I had a feeling like that, and the gestalt therapist told me that it was a thought and not a belief. I didn't agree with him and he wouldn't accept my perspective, and I decided that was it. Although overall he was a good therapist, this empathic failure on his part paradoxically got me to trust my own judgment.

The next thing that Gendlin taught me–and this is compatible with Rogers–is the idea of following the client's experiential track (Gendlin, 1968; Gendlin, 1990). Careful listening helps the client go from one step to the other. It may seem that step two is a detour from step one but if you listen carefully, to the felt meanings, you'll see there is a felt intuitive logic to why the client went from step one to step two. Therefore, we Rogerians are willing to follow a client even when they are off on presumably irrelevant topics. Other points of view assume that when a client changes topics sometimes they are trying to avoid going into something and want to stay away from it. We believe there is some intuitive logic to that. We believe that clients will come to things in their own good time when they're ready to deal with it. Even if they are avoiding it, they will come to it when they're ready to. Often they're not avoiding, it's just not ready to be processed yet. They'll come back to it when it's ready to be processed.

One of my favorite examples of this is if you've ever deviated from being a Person-Centered therapist, which I have, because I'm aware that I've tried out every single thing. You try to apply an insight. You have a brilliant insight you're sure is meaningful and you share it with the client. They say, "Oh yes; thank you," and they go on. Two or three weeks later they come back to it on their own. Now it works. Now it's meaningful. Of course, as I tell my students, "It's no fair to say, 'I told you so.'" The point is that they came to it when they were ready for it and that's when it's meaningful. This is the key point here: It is this unfolding step by step process that is important. Change occurs through this process but it can occur without any insight, or any noticeably emotional experience. It's a process. To quote Gendlin:

> "Rogers's method brought it home that the decisions a person must make are inherently that person's own. No book knowledge enables another person to decide for anyone. That goes for life decisions and life-style as well as, moment by moment, what to talk about, feel into, struggle with. Another person might make a guess, but ultimately personal growth is from the inside outward. A process of change begins and moves in ways even the person's own mind cannot direct, let alone another person's mind." (1984).

The last thing I want to talk about that I learned from Gendlin before I move on to Barbara Brodley, is that the whole idea that therapy needs to be experiential goes beyond responding to felt meanings. The other article I read shortly after "The Experiential Response" was Gendlin's article on working with schizophrenics from the Wisconsin schizophrenia project (Gendlin, 1967). That article I still use with my students. That article is about the power of meaning conveyed experientially. The whole idea of that article is about the power of being with the client at a level beyond words. What you say to the client is nowhere near as important as how you are with the client. I believe that. I think you and the client can talk about baseball and it can be therapeutic. I quote from Frieda Fromm Reichmann, who was a psychoanalyst. Some of you have heard this before: "The client needs an experience, not an explanation."

Let me give an example of this. This is from one of my years working as an intern in graduate school. I was working in a mental hospital, and was assigned a nineteen year-old boy who was hearing voices and was diagnosed schizophrenic. We met in my office and nothing was happening. I had a very wise supervisor. She said, "Why don't you take him for a walk?" So I did. Actually we didn't walk but sat outside on the hospital lawn. I abandoned doing therapy. I just decided to be his big brother. We sat and we bullshitted about this and that. Of course, you can imagine what happens when you bullshit about this and that. Inevitably, personal stuff comes up. You do therapy just naturally when it's happening. But it was without "doing therapy," if that makes any sense. He got so much better by the time I left the hospital he had volunteered to become an aide on the ward. He was going toward becoming a nursing assistant himself. There was one point when I thought I said something that really helped him but mostly I think it was just that kind of companionable relationship that did it.

I want to tell a story, and some of you have heard this too from John Shlien (1997) about an experientially meaningful encounter; one of my favorite stories. To quote myself:

[Shlien] tells of a client he was working with, a schizophrenic in a hospital, who began to cry, recalling something deeply sad about his life. The client blew his nose on his handkerchief and then he noticed that Shlien also had tears in his eyes. He offered Shlien the handkerchief, then drew it back as they both realized first, the sympathy of the offer, and second why it was withdrawn. Shlien writes "It is not the tears, but the exquisite awareness of dual experience that restores the consciousness of the self" (and not a word was spoken during this episode.)" (p. 76). (Bohart, 2016, p. 126)

To me that's a wonderful example of experiential encounter and by the way I think that is why empathic reflections help. They too create the exquisite awareness of dual experience that restores the consciousness of the self.

So as of 1969, I had found a home. At that time I felt more effective as a therapist than I had been before, and have ever felt since. Why ever since? Because I got corrupted. So how did I get corrupted? I got corrupted by interventionism. What is interventionism? It is the dominant philosophy today. I attend meetings with Association for the Development of the Person-Centered Approach folks, but I also go to meetings with groups like the Society for Psychotherapy Research and the American Psychological Association. All you hear about in those groups is "intervention." Everything is about interventions. "My intervention does this; my intervention does that." When you talk about how you work with a client, you talk about what interventions you're going to use. This is all over the place. It's not limited to cognitive behavioral therapy. Psychodynamic therapists talk about interventions. Narrative therapists talk about interventions. Family therapists talk about interventions. Emotion Focused therapists talk about interventions, and Emotion Focused therapy came from Client-Centered therapy.

I'm going to point out there's nothing wrong with thinking about therapy from an interventional point of view. Medicine thinks about things interventionally and we don't object to that. Thinking about therapy interventionally is perfectly legitimate, perfectly valid, and perfectly helpful. It's just that it's not Person-Centered therapy. Person-Centered therapy is fundamentally different. I just gave a talk to the Society for the Exploration of Psychotherapy Integration (Bohart, 2017) a few months ago, trying to make clear the difference.

People— identified with the dominant point of view— map Person-Centered therapy onto an interventionistic universe, and this is what happened to me in the seventies, because there were also a lot of Person-Centered people that started mapping Person-Centered therapy onto an interventionistic universe. How do you map Person-Centered therapy onto an interventionistic universe? There's a lot of research on the idea of empathy responses as interventions that do this or that, so you would talk about how you would plan your empathy response to have a deliberate effect. You would use this kind of empathy response when the client is doing this and that kind of empathy response when the client is doing that, so it becomes very planful and interventionistic. Again, there is nothing wrong with this. It is just not Person-Centered therapy per se. Gendlin valued this--and this is where I actually had to break with Gendlin. The reason he did this is because of the research he and others did which seemed

to indicate that the client's ability to focus on their experience was what made therapy work. Clients who were low on the ability to focus were not able to benefit from therapy, Gendlin said. That's why he developed the focusing technique and, by the way, focusing is a perfectly good, valid technique. I think it can be used in Person-Centered therapy at least the way I do it, and I'll talk about that later.

But I'm not going to talk about focusing. I'm going to talk about one other thing. Gendlin and a bunch of others, Laura Rice and others, got into the idea that you should design empathy responses so that they enhance experiencing. So you would deliberate try to use your empathy responses to have an effect. You would make them vivid. You would use evocative metaphors. So you would use words like "heavy" and stuff like that. You're really trying to have impact on the client's experiential process. I now see this as a shift from Gendlin's earlier work on felt meaning, which I thought was an explication of what we were already doing---trying to understand and hear our clients. I got into the idea of enhancing experience, and I did a lot of research related to that. I still thought I was being client-centered.

Then I had the fortune, or misfortune, at the 1988 Leuven conference of hearing Barbara Brodley (Brodley, 1990). She gave a talk where she basically said Client-Centered therapy is different from Gendlin's experiential therapy. I was absolutely shocked; not only shocked, but devastated. It was like my whole paradigm had been upset. It took me a long time to process that, but I finally came to agree with her. What she was saying was that when you're responding to enhance experiencing you're doing something different–this is such a key point– you're doing something different from listening to the whole person. Now, as a therapist, if I'm trying to enhance experiencing, I'm looking at or listening to a *part* of a person. That may be a perfectly legitimate thing to do from another point of view, but it's different from listening to and dialoging with the whole person. I believe in general the idea of interventionism is fundamentally different from whole person dialogue as an approach to therapy. I came to agree with Barbara. I realized that enhancing experience hadn't worked for me anyway. In fact interventionism hasn't worked as a philosophy for me. Finally, the idea of enhancing experiencing doesn't make philosophical sense. We're *always* experiencing.

Barbara Brodley brought me back to Rogers. So now–I have to get this in–even though I still think the idea of felt meaning has a lot of truth in it, I would say now that I don't respond to felt meanings so much anymore.

I don't deliberately do that, and I have to say this because I couldn't resist it, I now respond more "broadly" than that.

So now I'm going to tell you now what I currently think and this may or may not resonate with you–I don't know where you all are now. I now am back to being a Person-Centered therapist but I come at it from my own direction which is primarily based on Carl Rogers' statement to Martin Buber in 1957 (Cissna & Anderson, 1994). What he said was that therapy was a meeting of persons, or more accurately a byproduct of a meeting of persons. The meeting of persons comes first; therapy is a byproduct. That's basically what I think: Therapy is a byproduct of a meeting of persons. I want to read you a quote from the developmental psychologist Allison Gopnick (2016). This is from her recent book called the *Gardener and the Carpenter*. I think it's a wonderful description of Person-Centered therapy only it's in the disguise of talking about parenting. Gopnick is a research developmental psychologist at Berkeley. Gopnick is opposed to "parenting." She contrasts two models of parenting. She says: " 'to parent' is a goal-directed verb: it describes a job, a kind of work. The goal is somehow to turn your child into a better or happier or more successful adult…. The right kind of parenting will produce the right kind of child…" (p. 3). She calls this the 'carpenter' model of parenting. By contrast, she argues for the metaphor of parent as 'gardener.' She goes on to note that parenting

> "…is not a form of work, and it isn't and shouldn't be directed toward the goal of sculpting a child into a particular kind of adult. Instead, to be a parent…is to be a part of a profound and unique human relationship, to engage in a particular kind of love… Love doesn't have goals or benchmarks or blueprints, but it does have a purpose. The purpose is not to change the people we love, but to give them what they need to thrive" (Gopnick, 2016, pp. 9-10).

> "So our job as parents is not to make a particular kind of child. Instead, our job is to provide a protected space of love, safety, and stability in which children of many unpredictable kinds can flourish. Our job is not to shape our children's minds; it's to let those minds explore all the possibilities that the world allows. Our job is not to tell children how to play; it's to give them the toys and pick the toys up again after the kids are done. We can't make children learn, but we can let them learn." (2016, p. 20).

I'm not sure I know any better description of Person-Centered therapy.

In that regard, I'd like to say a word about empathy responses. Empathy responses are not interventions. We are not trying to do *to* the

client. We are not 'providing' empathy as if it were a drug. We are not *using* empathy to access emotions, enhance experience, help client's process, provide support, increase mentalizing, stimulate insight, or whatever. As some of you know, toward the end of his life, Rogers said he wasn't trying to reflect feelings. He was trying to test his own understanding. The direction of therapy is not from therapist to client, but from client to therapist. I am trying to receive and hear the client. If I'm intervening with anyone, I'm intervening with myself.

Peter Schmid (2004) says that therapy is not I-thou. Therapy is thou-I. In that regard I'd like to give you a little different way of thinking about empathy and oddly it contradicts Rogers. I'm going to read Rogers and then give my alternative view. He says "Empathy is the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view" (Rogers, 1980, p. 85). From the client's point of view. "It is the ability to see completely through the client's eyes, to adopt his frame of reference. It means entering the private perceptual world of the other, being sensitive moment by moment to the changing felt meanings which flow from this other person. It means sensing meanings or which he or she is scarcely aware" (Rogers, 1980, p. 142).

I'm going to borrow Marge Witty (sitting next to me) to illustrate my point of view. So empathy is for me to face Marge, project myself into her head, and see it through her eyes. That's how Rogers thinks about it. Right? Face to face. I ran into this quote a while back. I really liked it and I think it gives a different view of empathy. This is from Antoine de Saint-Exupéry, the author of *The Little Prince*. "Life does not consist of gazing at each other but at looking outward in the same direction" (de Saint-Exupéry, undated). So, the way I think of empathy is just like myself and the client are sitting next to each other and we're both trying to look out at what the client is looking at. It could be something out of her life. It could be something inside her but we're really trying to look at it together. I think that's a better metaphor than the idea of me trying to get in their head. So I say, "Imagine you and the client are on a hill looking at clouds. The client says that she sees a cloud that looks like a lion. It doesn't look that way to you. Perhaps it looks more like a horse. But you aren't judging whether she is right or wrong. You're trying to see it as she sees it. So in essence what you're trying to do is say to the client, 'I'd love to understand you. I want to see it as you see it, so help explain it to me.'" Some of the following things happen.

First, in order to make it clear to you, the client must better articulate her own vision to herself. So in explaining to you, she comes to know her

own vision better. Second, and this is really important, in explaining to you, through the sharing process, she becomes aware of another's mind, and of the need to communicate to other minds. In other words, she develops empathy for you. She must practice understanding you as well. If you watch Rogers and Gloria you will notice how often Gloria tests her understanding of Rogers as much as Rogers tests his understanding of Gloria. Third, by looking out at the clouds together and trying to share an understanding, the client is learning how to build bridges to other people. And you helped in this by dialoguing with her to share her understanding.

I want to say a little about psychotherapy integration. I've always been an integrationist. Even in my early days of being a Client-Centered therapist I was. At that point I took license from the writings of books like *New Directions in Client-Centered Psychotherapy* (Hart & Tomlinson, 1970) that argued that Client-Centered therapist could offer techniques, if they did it in a respectful empathic two-person way. And, of course, Carl Rogers himself supported that and his daughter Natalie was a good example (Bohart, 2012). I still believe that. I believe it is not whether I offer a technique but how. That's why I think of Allison Gopnick giving toys to her kids and picking up the toys afterwards but not telling them how to play.

If I give a client a technique, it's for them to use and to play with. I'm not the expert who knows what's best for them. To me that makes all the difference. Do I come from an expert's stance or do I come from a kind of fellow traveler, friend, colleague, person on the road, bystander. When the client is looking for something in the moment and something to persevere, it might be useful to them as part of our process together, just like if he was looking for something to hammer a nail and I had a toolbox with a hammer in it. The difference is that he's the expert on what he needs. If he does not want what I offered, we don't use it. If he tries it and doesn't like it, he knows best. We both learn from this encounter. Remember the steps are the most important thing. It's the encounter that matters. It's the connection that matters.

I'll end with this little bit from an autobiographical novel I'm writing and this just sort of summarizes everything I said:

> "The client comes to see me…I begin to empathically listen to them. My interest is in meeting them in the moment…I listen carefully to what they have to say. I try to sensitively grasp the sense in what they are saying and I reflect it. I try to join with them so that we are sharing that understanding. I go step by step. I am, in the sense of following a story, trying to follow them. What I am saying back to them is, in a sense, 'If I follow you correctly'… I believe that as they begin to be heard, they will begin to zero in on what

bothers them. They will be able to stand back and gain perspective. They will begin to listen to themselves in a friendly manner. They will find insights and intuitions bubbling up out of their pre-conscious awareness. They will find themselves relaxing and being more at home with themselves, and that may be by itself therapeutic and enough…They may also discover that some of their crazy behavior has made sense. It did not arise from craziness within.

"The steps they take in our discussion will not necessarily follow a logical unfolding path. It may go here and there. Something may bubble up that is apparently unrelated and they may talk about that. But it turns out that it is intimately connected. This is the organismic wisdom process. Overall they are changing through this process. As they listen and hear each bit in each moment, as they dwell in each step, their organism is assimilating it and they are changing. They are becoming more balanced and more wise. They may not necessarily come up with the answers that they had originally sought. But they become different… They find new and more ecologically wise ways of functioning in the world. By ecologically wise I mean that their solutions take account of their situations. They balance the factors in their life, including what is wise for others.

I may at given moments also suggest a technique if it seems like something the client might want to try. I trust the client, as an intelligent agent, to dialogue with me on what they want. If the client decides to use it, we try it. It becomes a step on the path. It is the steps on the path that count. Whatever comes out of it becomes fodder for the next step.

In one sense the process may never get 'finished.' It is not like a story where, at the end, all loose ends are wrapped up….[Clients] leave because they are now finding their way in their worlds more effectively on a moment to moment basis. Like our therapy, which was moment to moment, life is a matter of moment to moment decisions unfolding towards the future and they are finding that they are better at riding that wave. They still may have struggles and unclarities. But they have learned how to live better with them and to live a productive life in spite of them and to work with them and on them when they arise, gradually assimilating them over time" (Bohart, in preparation).

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Hello, Neighbor: A Process of Person-centered Mentorship Inspired by Carl and Fred Rogers

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Abstract. *Though professionally unaware of each other, Carl and Fred Rogers had much–including religious upbringings, early career interests in child well-being, and primary aspects of their philosophies on life and human potential–in common. Carl Rogers became one of the most influential American psychologists to date, in formulating person-centered approaches to psychotherapy and life, and as a children's television host Fred Rogers was–and has remained, in the eyes of generations of kids and adults alike over the last 50 some-odd years–in many ways perhaps the most exemplary late 20th century embodiment of Carl Rogers' proposed way of being. Here, I–a mentor to motivated students in the meteorological and psychological sciences, and others in wider life–discuss my discovery of the person-centered approach, via childhood exposure to Fred Rogers. I provide perspective on the ways the person-centered approach can be utilized to foster more effective and meaningful mentorship and learning-based relationships.*

"People are just as wonderful as sunsets if you let them be. When I look at a sunset, I don't find myself saying, "Soften the orange a bit on the right hand corner." I don't try to control a sunset. I watch with awe as it unfolds." – Carl Rogers (1902-1987; quote 1995a)

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"…Deep down, we know that what matters in this life is more than winning for ourselves. What really matters is helping others win, too. Even if it means slowing down and changing our course now and then." – Fred Rogers (1928-2003; quote 2002, see footnote[2])

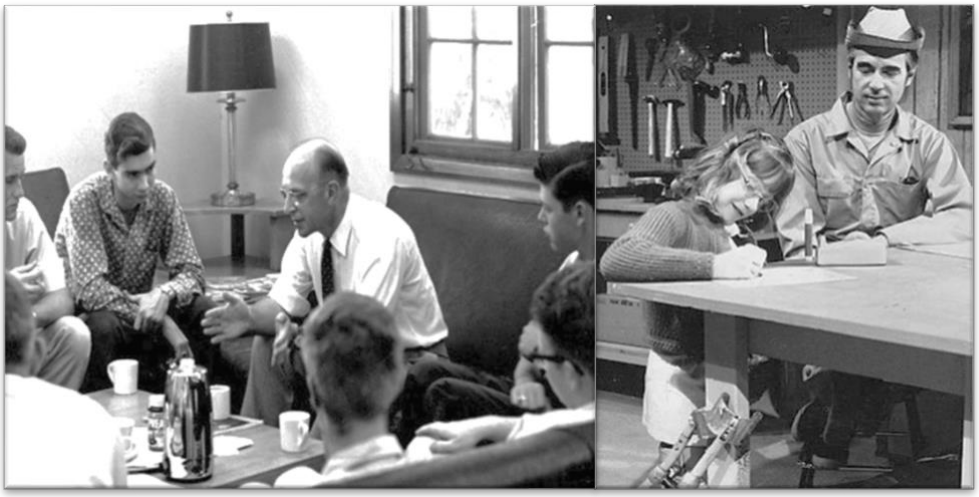

Figure 1. Carl[3] and Fred Rogers[4].

Growing up, I aimed to become a meteorologist. My career path, however, changed through an accumulation of high school and early college experiences, including the difficult revelation that a math disability precludes me from completing the meteorology degree. Thanks in part to steadfast supporters, including several devoted mentors in the meteorological and psychological fields, I have been able to find a satisfying career track. I am a psychology Master's candidate working to bridge gaps in research related to the psychology of weather and climate (Bolton, Ault, Greenberg, & Baron-Cohen, 2018; Bolton, Blumberg, Ault, Mogil, & Hanes, 2020; Bolton & Ault, 2020; Bolton, Mogil, & Ault, 2020). I am likewise interested in psychotherapy, both generally and with respect to psychological problems that arise due to severe and dangerous weather (Bolton, Stewart, & Mogil, 2020; Bolton, Mogil, & Stewart, 2020). I intend to eventually pursue a counseling degree and specialize in natural disaster

[2] In a 2002 commencement speech at Dartmouth University; please see https://news.dartmouth.edu/news/2018/03/revisiting-fred-rogers-2002-commencement-address.

[3] McClanahan, J. (1960). Carl Rogers with students [digital image]. California Institute of Technology, Calisphere. http://archives-dc.library.caltech.edu/islandora/object/ct1%3A9271

[4] [Photograph of Chrissy Thompson and Fred Rogers on "I Am, I Can, I Will"]. (1981). Wikimedia Commons. https://commons.wikimedia.org/wiki/File:Fred_Rogers_and_Chrissy_Thompson_on_I_Am,_I_Can,_I_Will.jpg.

trauma and meteorologically-focused counseling from a primarily person-centered perspective.

Mentorship kept me afloat following the math diagnosis early in my college career. Ever since, I have worked to pay forward the energies and efforts that were invested in me not just then, when I needed guidance the most, but while I was in high school, fresh to professional meteorology, and which continue to be invested in my ongoing growth and journey of lifelong learning. I have been a mentor to nearly two dozen motivated middle and high school students, college-level students, and others in daily life. Most of the relationships in which I have been a formal mentor have been the result of a summer weather camp program I co-directed from 2013 to 2020.

Mentorship is governed as much by trial-and-error, mistakes, and failure as by successes. Moreover, like many life experiences, it is governed by various transactional, interpersonal processes. Here, I intend to more fully elucidate the processes I consider essential to a person-centered approach to mentorship and learning–not only how they originated in my life but also their practice, application, and underlying philosophy. I aim to bring together and more formally codify these ideas so far written about in lesser, piecemeal detail (Bolton & Mogil, 2019a, 2020; Mogil & Bolton, 2019a, 2019b) as a specific perspective on Carl Rogers' person-centered approach, recognizing my ideas may coincide with and/or be approximated by the methods of others who have worked or are working in the learning facilitation and education spheres. Along the way, I will also show how my views have also been mightily influenced by the late child educator Fred Rogers (unrelated to Carl, though they shared much overlap in perspective, including religious upbringings and interests in childhood development).

Carl Rogers himself generalized the principles and "core conditions" of person-centered psychotherapy to learning and teaching contexts (e.g., Rogers, 1969, 1995b). He argued that the personal growth which person-centered modalities can elicit produces a deeper, more rapid learning that is pervasive beyond classroom contexts (Rogers, 1977). But whereas his viewpoint encompassed a radical centering on the student-learner as the *sole* driver of his or her own learning, I prefer a somewhat more mentor-guided approach. That's not to say I don't believe in student-driven learning; actually, at the most fundamental level, relationships in which I consider myself a formal mentor stand on the belief that education is supplanted by the self-driven learning Rogers championed. Rather, while I seek to facilitate student learning I also conceptualize mentorship as heavily transactional: I believe the formal mentor and student (note, I interchange the terms mentor and teacher; and student, learner, and mentee) enter into a symbiotic relationship which has the power to affect each person quite directly, and that both individuals in the relationship learn from one

another in the course of the mentor serving the mentee as a facilitator of learning.

Functional Aspects of the Mentoring Relationship

This view of mentorship-as-symbiotic-relationship emerged from the observation of one of my mentors that education–via teaching–traditionally a one-sided communication affair–has long been synonymous with indoctrination and is therefore much more passive (for a review and philosophical discussion, see Hansson, 2018). Learning as a process, in contrast, is active and engaged (Corbett, 2005; Kintsch, 2009; Smart & Csapo, 2007; Phillips, 2005; Watkins, Lodge, Whalley, Wagner, & Carnell, 2002). Further, it is a common postulation in everyday life that *to learn* is taken to mean *being educated*; the two are often conflated and synonymously interchanged. I have come to believe that a person cannot truly learn, in the most genuine sense of the word–beyond rote memorization, that is–without first being self-motivated and employing self-regulation processes to actively seek out and acquire knowledge for him or herself.[5]

Teachers learn and learners teach but it is far more realistic to say that each of us learns and teaches every day, outside of "learning" and "teaching" contexts and often without being aware we are doing so. Mentoring relies on a person wishing to share something (knowledge, skills, or experiences), but it is and can be done by everyone, because every social interaction is inherently defined by the existence of potential for an individual to teach another in some manner, or to learn something, even if just in passing and/or for a few moments. One can thus mentor without such teachings being formally defined or declared, and in this sense a "mentor" could be anyone who is modeling behavior in a given moment. Mentorship, further, transcends age (there are no limits or expiration dates on learning or teaching) and all other individual and/or socio-cultural differences. While some are more dedicated than others and actually view themselves as mentors (in formal relationships that typically have expiration dates), we are–all of us–an interconnected web of mentors and mentees on a lifelong learning journey.

[5] This is not merely ideological or pedagogical hyperbole; looking to the empirical literature, there is much discussion on self-regulation's role in learning (e.g., Burman et al. 2015; Heikkilä & Lonka, 2006; Panadero, 2017; Schunk & Ertmer, 2000; and Zimmerman & Labuhn, 2012), and much empirical evidence to suggest that students not only benefit from (e.g., Gingerich et al., 2014; Hébert & Hauf, 2015; Huffaker & Calvert, 2003; Prince, 2004), but also prefer active learning strategies (e.g., Cavanagh et al., 2014; Lumpkin et al. 2015; Miller & Metz, 2014; Smith & Cardaciotto, 2011; Ul Huda, Ali, Nanji, & Cassum. 2016).

A recent review (Chen, Watson, & Hilton, 2016) reveals similarities in most common research conceptualizations of mentorship. Schockett and Haring-Hidore (1985), Ragins and McFarlin (1990), Dreher and Ash (1990), Scandura (1992), Pollock (1995), and Hu and colleagues (2011), for example, all focus on career-related and psychosocial functions of the mentoring relationship. Others, including Wilde and Schau (1991), Sands and colleagues (1991), Chow and Suen (2001), Fowler and O'Gorman (2005), and Crisp (2009) focus not just on these factors but also (for example) on role-modeling and coaching, emotional support, and the facilitation of learning opportunities. I draw on many of these aspects in facilitating a primarily student/learner-centered approach. Be aware, however; myriad other frameworks exist.

While these various processes of interpersonal symbiosis are at work within the mentor and mentee, the relationship's timer invariably counts down. Indeed, mentorship is comprised of stages (see Haensly & Parsons, 1993, for one view of how these work). My view is that one starts out as a student primarily focused on learning, and then slowly begins to reciprocate these and other learnings to the mentor. All mentees eventually grow out of formal mentorship, but never stop learning from the mentor (and the same is true of the mentor, who can always learn from the mentee; thus, because mentorship is symbiotic and transactional, these terms may only be arbitrary descriptors).

I previously took part in a conference panel on mentorship (viewable at https://www.youtube.com/watch?v=4_OoU4zFu0A) where, consistent with some of the aforementioned frameworks, the term was conceptualized as a "professional friendship." I prefer to view mentorship as an active state of being in which one is either mentor or mentee, and often both at once. One who consciously acknowledges and strives to operate within this state, teaching and simultaneously learning, can of course have a "professional friendship" with another who is in this state. But beyond simply being in a "zone" or state of engagement, and beyond simply giving another person information, I believe the mentor's role is to motivate the individual in his or her own learning, to enable self-driven growth. I therefore ask myself not "how can I better educate the individual," but rather, "how can I better enable the learner to meet his or her own needs."

Applying Person-centered Principles to Mentorship and Learning

"*In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?*" Carl Rogers (1995b)

"There's a world of difference between insisting on someone's doing something and establishing an atmosphere in which that person can grow into wanting to do it." Fred Rogers (1995)

Carl Rogers staunchly defended the view that people are innately *good* and in possession of latent potential; that each person fundamentally possesses a desire for, and can manifest a tendency towards, personal growth and integrated wholeness. He supported Abraham Maslow's notion (Kaufman, 2018, 2020) that, freed from concern for the most basic needs, people are drawn towards growth and can become fully-functioning and therefore "self-actualized." These are foundational concept in person-centered psychotherapy.

Indeed, Carl Rogers believed (Rogers, 1951, 1957, 1958) that positive helping relationships occurred, and the proper environment for client growth was created, when the therapist was (1) *congruent*, or genuine, able to honestly express feelings for the client; (2) when the therapist could adequately *empathize* with the client; and (3) when the therapist could *demonstrate unconditional positive regard* for the client so as to accept him or her exactly as he or she was as a person, in whatever the individual's presenting state, as he or she *was*, in essence, the feeling or emotional state that was being expressed (Rogers, 1995b). Believing himself only a guide rather than an instructor, Rogers was non-directive in helping clients towards self-actualization, preferring instead to ask open questions, re-frame, reflect, and paraphrase stated concepts, ideas, and feelings, and to gently encourage clients forward in seeking out and traversing through their own reflections and introspections. This is the basic model I apply to learning-focused, and particularly, mentorship-based, interactions.

The purpose–and sometimes, the challenge–of unconditional positive regard, and often a barrier to achieving congruence in the mentoring relationship, is recognizing and acknowledging the learning-focused individual as intrinsically *good* in whatever state he or she exists presently. Mentor-mentee congruence is made possible when the mentor first embraces him or herself with unconditional positive regard, via self-directed empathy (compassion) and acceptance, transparently acknowledging his or her own state as *good* and then extending this same grace and acceptance to the mentee. This often means, as a formal mentor, recognizing and accepting one's own failings and imperfections. This process is activated again and again with each interaction; hence, the mentor must reassess him or herself regularly. Congruence is developed only through an awareness earned by self-reflecting. Just as one cannot, for example, teach another person to dance without him or herself first learning

to dance, so too can the mentor not demonstrate other-oriented compassion without first expressing self-oriented compassion.

Once congruent, the mentor is better able to lead-by-example and reflect and model to the mentee essential behaviors, beliefs, and values (note, this concept can also be applied to leadership positions). It is crucial that the mentor recognizes that attitudes and beliefs are caught, not taught (see Aspy & Roebuck, 1974; and C. Rogers, 1995a, p. 309, for discussion), and that some of the most important lessons for mentees come through the mentor's own actions and examples. Effective, formal mentors are personally as well as professionally cognizant, striving to model appropriate behaviors to their mentees. Ideally, the mentor grounds him or herself in humility and selflessness and strives to remember that what he or she is doing in mentorship is bigger than him or herself alone. The learner-oriented mentor works from this position not to mold the mentee into a mirror image of him or herself but to allow the mentee room to grow into his or her own person.

Taking a Broader View: The Development of my Specific Approach

"*I'm very concerned that our society is much more interested in information, than wonder; in noise, rather than silence. How do we do that? How do we encourage reflection? Oh my, this is a noisy world*." Fred Rogers[6]

Carl Rogers' psychotherapeutic principles notwithstanding, my approach also incorporates the life principles of renowned television host and child educator Fred Rogers, of whom I have, since childhood, been a viewer and fan. The overlap in the principles and philosophies espoused by Carl and Fred Rogers has been discussed elsewhere (Gladding & Wallace, 2012; Palmer & Carr, 1991; also see Lietz, 2014), but not in a mentoring context. I believe Fred's views contribute much to person-centered mentorship, and that from him we can discern the notion of mentorship as a mindset.

Mentorship, in my view, is a mindset because self-reflection is necessary if one is to successfully model behavior. Such introspection requires a certain mindful commitment and willingness to embrace not only growth, but also, perhaps, the side of oneself with which one is not necessarily pleased–yet, this can be a deeply rewarding experience. That self-reflection is necessary is a logical proposition, because the essential qualities, traits, and ideals the mentor wishes to convey are, as Rogers stated, "invisible to the eye" (F. Rogers 2005, p. 10). They–humility and selflessness, to name just two–are inherently intangible traits that must be

[6] In a 1994 interview with Charlie Rose; please see https://www.youtube.com/watch?v=djoyd46TVVc.

sorted out. The mentor would not find and acquire, and then could not model, them, without introspection. The state of mind one inhabits within this process lends itself to personal growth and, in turn, allows the mentor to be more congruent–inwardly as well as with mentees.

This realization emerged during some of my earliest serious discussions of mentorship-as-process, with a mentor who had also been a childhood viewer of *Mister Rogers' Neighborhood* and subsequently embraced Fred's wisdom. I began incorporating regular self-reflection into my mentoring process (Bolton, 2015) and my belief that mentorship is transactional soon followed. It was on an unconventional path to enlightenment that I first became acquainted with these varied person-centered principles, through my childhood exposure to Fred Rogers. Growing up in the mid-late 1990s and early 2000s, *Mister Rogers' Neighborhood* was a staple on my television, and it is not unreasonable to posit that these principles lay dormant within my mind until activated later by my mentorship experiences. They have long been part of my philosophy (Bolton, 2015; Bolton & Blumberg, 2017; Bolton & Mogil, 2019b).

For many, myself included, *Mister Rogers' Neighborhood* and the gentle approach of Fred Rogers himself offered stability. His was a devoted demonstration of the concepts put forth many years before by Carl Rogers. Much as Carl Rogers endeavored to create a safe and welcoming therapy environment, Fred Rogers sought to create a space in which each person watching his television program, "visiting" with him, parasocially, could feel, regardless of individual difference, accepted exactly and entirely as unique individuals. The following quote (F. Rogers, 2003, p. 95) showcases his belief not only in unconditional positive regard but also a form of congruence:

"*When we love a person, we accept him or her exactly as is: The lovely, the unlovely, the strong along with the fearful, the true mixed in with the façade, and of course, the only way we can do it is by accepting ourselves that way.*"

One may see, also, in Fred Rogers, echoes of Carl Rogers' belief in self-actualization (Fred Rogers Center, 2019):

"*Knowing that we can be loved exactly as we are gives us all the best opportunity for growing into the healthiest of people.*"

An ordained minister who actively (but quietly, in a way that avoided openly proselytizing) put his beliefs into practice, and whose beliefs informed a view not dissimilar to that which is central to person-centered psychotherapy (Harris, 2019; Salonen, 2020; Wilczynski, 2019), Fred Rogers practiced radical kindness and viewed whomever he was with

in the moment to be his "neighbor." He strove to instill, on *Neighborhood* and in each person he interacted with, what he called an "expression of care" (Eisenstat, 2018; F. Rogers, 1969). Comparable in essence to Carl Rogers' empathic stance and unconditional positive regard, this expression was and is still, today, a demonstration of the ways in which he sought not only to "make goodness attractive" (F. Rogers, 2003), but to make feelings mentionable and, therefore, more manageable (King, 2018; Klaren, 2019). He quite literally embodied the empathic, congruent, self- and other-acceptant way of being put forth by Carl Rogers. One participant in a discussion-based presentation I gave on this topic at the 2020 Carl Rogers Conference, hosted by the Center for Studies of the Person, after viewing a video of Fred Rogers, even remarked that he physically carried himself and gestured in a manner similar to Carl Rogers.

Amidst renewed public interest resulting from the recent *Won't You Be My Neighbor?* documentary (2018) and *A Beautiful Day in the Neighborhood* film (2019, inspired by the relationship between Fred Rogers and journalist Tom Junod; see Junod, 1998/2017, 2019), scholars concerned with the philosophy and methods of effective teaching have long discussed, and are still discussing, Fred's social-emotional-focused pedagogy (e.g., Evans, Russell, Furgione, & Sheridan, 2018; Kerry, 2015; Long, 2015; Serriere, 2018; Sharapan, 1977; Poole, 2017). Researchers, meanwhile, have consistently found positive effects on psychosocial and personal emotional functioning not only for child, but also adult, viewers of *Mister Rogers' Neighborhood* and its modern offshoot *Daniel Tiger's Neighborhood*.

These, consistent with other mass and electronic media findings (e.g., Rushton, 1979; Mares & Stephenson, 2017), are related to improvements in task persistence and rule obedience (Friedrich & Stein, 1973, 1975), prosocial behaviors and levels of social contact (e.g., Coates & Pusser, 1975; Coates, Pusser, & Goodman, 1976; Cosgrove & McIntyre, 1977; Friedrich and Stein 1973, 1975), and increased empathy, self-efficacy, and emotion recognition (Rasmussen et al. 2016). Newer research has even begun to explore, with some promising findings in preliminary small-sample studies, possible media-psychological effects of *Neighborhood*-viewing on life and social skills in children on the autism spectrum (Dotson et al. 2017); and on syntactic language in children with Down Syndrome (Burnett & Lund, 2017; Jameson, 2019).

Some Specific Thoughts on Applications of Person-centered Mentorship

Summarizing to this point, my view is that learner-centered mentorship is conducted by a person wishing to share knowledge or

experience with another, whether or not it is within the bounds of a formally-declared relationship; that mentorship is transactional–that the mentor can learn from the student, since a mentor is anyone who models behavior and attitudes and beliefs are naturally and inherently caught, not taught–and that periods of formal mentorship generally exist between individuals in such a relationship, but that such symbiotic learning can be sustained past this timeline. I also view mentorship *as a mindset*, because people who formally consider themselves mentors regularly introspect on their own imperfections, in order to connect with the learner. Finally, insofar as it entails a process, I believe that *the goal of mentorship is to enable the learner* to become self-actualized with respect to his or her own learning and that the mentor's role is to guide this journey.

Since teaching at weather camp in 2014, I've made mentorship of weather-passionate K-12 students a primary goal. In addition to after-camp mentorship of other students, I and my former co-director and longtime research colleague, meteorologist H. Michael Mogil, who owns a weather learning-facilitation company and who has long facilitated high school and college student internships–have involved five high school students in some of my research (Allen et al., 2020; Bolton, Mogil, Ault, & Harvey, 2018; Bolton et al., 2019, 2020) or their own projects.[7] Attendees of the 2019 Annual Meeting of the National Weather Association had the chance to meet two of them, as they presented our research as well as one of the morning weather briefings (see Allen, Serré, & Bolton, 2019 for their recap of experiences). They've helped devise surveys and compile results for publication, and assisted in designing and presenting conference materials. Hopefully, they've come to more fully understand scientific research and principles of both meteorology and psychology.

Depending on individual mentee interests, I've provided guidance on weather forecasting, writing and online blogging, interpersonal and professional communication–one mentee maintains a weather-focused Facebook page for a readership of over 15,000 people–and photography and videography. Other guidance has focused on professional skills, like networking, and managing life and high school demands.

[7] Mogil and I have a long collaborative history dating back to a high school internship I worked under him.

Figure 2. Collage of mentorship photos. Leftmost photo: High school weather camp student and then-research assistant/intern Grace Carpenter Top-right photo: The author (Matt Bolton, L) with high school weather camp students and research assistants/interns Dylan Allen (middle) and Aaron Serré (R) after a map analysis workshop at the 2019 Annual Meeting of the National Weather Association. Bottom-right photo #1: Then-middle school weather camp student Nico with a mentored science fair project. Bottom-right photo #2: Former high school weather camp student and research assistant/intern Jake learning video editing techniques for a camp project.

Sometimes, potential mentees turn down offers of guidance. Other times, mentorships decay due to conflict or lack of interest. Conflict–whatever its source, though it often manifests through lack of communication or various factors that play into mentor-mentee match strength (Hodges, 2009; Rhodes, Schwartz, Willis, & Wu, 2017)–is the most irredeemable, destructive force that can act upon a mentorship. It can result in one of the individuals, perhaps inexplicably, refusing to acknowledge the other, with reconciliation attempts on the part of the other being to no avail. Such situations can induce deep questioning and doubt for the student (here, the person to whom the negative behavior was modeled), who may think he or she is at fault. Alternatively, mentor-mentee match strength can erode over time for any number of reasons. Fortunately, and this has most often been my experience, formal mentorship periods in

which one individual is recognized as more of a teacher and the other more of a student typically end naturally, with grace.

I believe the psychosocial aspects of mentorship are just as important in fostering student growth as those that are career-focused, that the emotional well-being of the learner is as important as the physical; and further, that the psychosocial aspects are just as important as the actual epistemic learning that the mentoring relationship facilitates. Thus, I strive to foster mentoring relationships that appropriately straddle the boundaries between teacher and friend and help fulfill the requirements of the self-actualization process (see Kaufman, 2018, 2020).

Within this, the-mentor-as-advisor is a topic of importance to me. This is necessary to consider since the mentor may be called upon to give more than simple professional guidance, or feel the need to serve as a sounding board. The mentee might be going through difficulties; these could be academic issues or on-job problems, trouble with friends or in a significant relationship, burnout in some facet of life, or something else entirely. Perhaps the mentee is depressed or anxious, confronting a physical injury or medical condition, or feeling inadequate when confronting self-criticism and doubt; or a family member or close friend passed away recently and the mentee is struggling with this event. Whatever the case, it is important that the mentor knows how to approach sensitive topics. Fortunately, there's no shortage of ways in which to engage and instant messaging, e-mail, and video chat can easily facilitate communication.

Familiarity with some basic psychological first-aid concepts and mental health intervention principles is helpful (see, e.g., Ruzek et al., 2007, and Wells, 2005; Bolton & DePodwin, 2019 also has simple coping strategies), but one does not need, necessarily, to play the part or have the training of a psychotherapist–rather, only to possess a sincere desire to help and willingness to listen in times of need (in moderation, of course). Mentorship is a growth process, and in helping the learner become self-actualized, so too does the mentor transform him or herself–learning from and, importantly, *through* the process, alongside the mentee (just as psychotherapists can learn from clients about the mechanisms of emotional processing and change; e.g., Pascual-Leone & Greenberg, 2007). Many factors affect mentee well-being, but listening is often the best medicine for mildly-distressed mentees–. One strategy that can act against many of these simultaneously is to guide the mentee in establishing a sense of meaning and purpose that will sustain him or her through hard times. It is all too easy for a person to become discouraged and begin to think negatively. A sense of meaning–that what one is doing is worthwhile despite the hardships one will inevitably face–can help buttress oneself against these feelings and

positively affect well-being (see Grouden & Jose, 2015, for a review). Helping the mentee identify the values which are important to him or her, and then helping him or her remain committed to them, is another helpful strategy (Bramwell & Richardson, 2018; Sharp, Schulenberg, Wilson, & Murrell, 2004).

As an aside on my own experiences as a mentor in the meteorological field, I have observed that pre-college student mentees sometimes have only fledgling weather interests that may not withstand the emotional and other trials of adolescence. It is important to gently nurture these students–and those focused on other career pathways, when weather is not the focus–taking care not to overwhelm them with too much at once but also not to underwhelm them with a dearth of enthusiasm or opportunity. Pre-college and early-career mentees should be engaged with a variety of opportunities and their exposure to the breadth of the field, whatever it is, should be maximized. Further, if one cannot answer a learner's question, a tried-and-true method is directing them to someone who can. These principles, of course, can and should be applied outside of the meteorological example I have just provided. Students in any topical area should be led or better yet accompanied, and not thrown, into their area of interest; they should be encouraged to continue on their journey of self-learning; and help should be rendered them when deemed necessary and appropriate.

I have also observed that many weather-interested kids and teens–myself included, back in the day–have few other interests, finding their desire for a meteorological career to be all-consuming. That seems to be a common theme, and the fact that young students may be alone in this interest at school and possibly in the wider community (at least within his or her social network) is another consideration warranting attention. The young learner's constant focus on weather can be challenging and complicated (not just for the student, but for parents and school counselors as well) and can interact with any number of factors. Sometimes, whether the learner is young or old, circumstances beyond individual control–family or wider social problems, non-academic changes at school, car accidents, sport-induced or other extracurricular injury, or other serious neurological or psychological problems, and disease, to name just a few–may develop and add serious strains and stresses.

In these cases, especially for younger learners, focusing on weather (or whatever thing about which the learner cares) and other possible passions as distractions (and the mentor-mentee relationship more generally, through learner-venting and the mentor's sharing of coping skills) can be a life-saver. One of my mentees, for an example of a situation I've fielded in this arena, has been challenged by acute, progressive hearing-

loss; alongside a nurturing of the student's meteorological, and encouraging of other, interests, I've informally provided advice about simple coping techniques, goal-setting and pursuit, and the maintenance of motivation.

Not if, but when the mentee begins to doubt or to experience hardships, there is a tendency to spiral downwards; this is where a mentor can step in and be a highly positive and stabilizing influence. And, being aware of the potential for drops in mentee self-esteem and/or well-being, the mentor can take care to help prop the mentee up. Guidance and, if available, experiential learning opportunities–even of a long-distance nature, as are those I often provide my high school students–can help stave off negative outcomes and set the learner back on track when negativities do occur. As an example of ways one can think outside the box about learner engagement, I've provided three students with the active-learning experience of proof-reading and providing feedback about several iterations of this paper, so they can better understand the academic writing process.

The positive outcomes of experiential, person-centered learning strategies are well-known (Cornelius-White, 2007) and have long been discussed within person-centered frameworks–especially with respect to the activation of learning for the whole person, affectively as well as cognitively (e.g., Rogers, 1995a). Learning involving the emotions is just as important as learning involving knowledge; where possible, strategies involving both aspects should be invoked to further the fullest levels of self-growth.

Employing active listening skills is one of the easiest methods by which the mentor can connect and provide counsel to learners. This involves processing what is being said (or perhaps not being said) and putting effort into genuinely understanding not only the "what" but the "why" of this content; trying to read body language and facial expressions if communicating in-person or through video chat, or intent if communicating through text; and hearing and noticing changes in tone, inflection, and emotional state, while accepting the individual for who exactly he or she is in that moment. Another method involves re-framing negative circumstances and helping the learner see and find the positives in different situations. The mentor's role in these situations becomes, on a metaphorical but also quite literal plane, to help the learner recognize opportunities for petting cats and dogs when they see them in the street–to help them find joy and happiness even in the apparently- and actually-dark moments of life.

I am not suggesting negative cognitive experiences be ignored (although they are normal, to a point), since at more severe levels such ignorance, or denialist behaviors, could be dangerous. However, the pain brought by the likes of social difficulty, minor anxiety and depression, self-

doubt, and/or grief can be blunted to some extent by a strong motivational drive and meaningful goal pursuit. Helping the mentee through difficulties–with a careful eye for when professional help may be needed, and then providing guidance through that process, if needed–is mentorship of the highest magnitude, at the heart of Fred Rogers' injunction to help others win.

Concluding Thoughts, on the Ethics and Process of Mentorship

To conclude, I want to briefly discuss the ethics of mentorship as I see them. Individuals should think carefully, when choosing to actively engage in mentorship, to determine the rules and values which will be maintained in the relationship (including that, with all mentorships of youth under legal age, one should regularly coordinate and communication with parents and/or guardians). These will differ depending on many factors that can combine at times but are crucial to the health of any mentorship. For example, one must consider the mentee's age and whether the mentee is a minor, or a college or minor student; if the mentee has a disability or learning-affecting condition; or if the mentee faces challenging socio-economic factors that could affect access to learning tools and resources. One must also carefully consider the power dynamics these relationships inherently involve, particularly if the mentee is a minor or a student–and especially if that student is under the mentor's direct supervision, say in a classroom environment or while working on a research project. Personal and professional boundaries are not only helpful, but necessary. This does not mean a level of friendship cannot exist–recall the notion of mentorship-as-professional-friendship–but rather that care and appropriate boundaries must be exercised.

The rules and guidelines I've set for myself are inspired by the American Psychological Association's Code of Ethics (https://www.apa.org/ethics/code/) as well as my own beliefs, values, and experiences on both sides of the mentoring relationship. This list distills these into a form that may help readers wishing to improve their own mentorships. Note that some apply to mentors, some to mentees, and some to both states of being.

1. Recognize that each person you interact with is unique. Strive to accept him or her no matter the differences existing between you.
2. Be honest but kind in evaluations. Criticism wrought is fear caught: Harsh, non-constructive critiques impede the mentor in achieving and maintaining unconditional positive regard, and discourage the mentee from trusting the mentor.
3. Aim to give the mentee space to grow and make mistakes. Don't immediately provide answers; rather, give gentle nudges in the

right direction. People learn (and retain) information best in working things out for themselves.

4. Whether mentor or mentee, be of benefit and do no harm. Should harm inadvertently occur, accept responsibility for your behavior and act to rectify the situation. Hold no grudges, even with yourself. Work to be the mentor you wish *you* could have, as you would (hopefully) strive to be the friend you wish you had.
5. Recognize that mentorships, while symbiotic, are inherently trust-based. Do not abuse the natural power differentials of the relationship. Uphold and model professionalism, precision, honesty, and truthfulness.
6. Remember that you don't (and won't) know everything–even, sometimes, after deep reflection–but that this is okay. What's important is how you respond to your lack of knowledge, and (inevitable) failures. Remember to be patient with yourself in the unclear moments. Forgive yourself when you do know the answers but may not understand or are disappointed by them.
7. Seek open-mindedness, humility, and selflessness; strive to remember that what you are doing in mentorship is bigger than yourself. Help others win, too.
8. Endeavor to be congruently present when interacting with the mentee; strive to *be* with, as well as to receive, him or her as fully as you can.

I hope this discussion–showcasing what I have so far learned and am passing on, from Carl and Fred Rogers and from my own mentors and mentees–will help make readers' own mentoring (and learning) endeavors more successful and effective. I have focused on pre-college mentorship because that is where my familiarity and activity is strongest, but many of these ideas, principles, and concepts can readily apply elsewhere. Mentorship is a mutually-affecting helping relationship (e.g., Frymier & Houser, 2000; Hodges, 2009) that can apply in all facets of life, both formally and informally. Perhaps the most crucial element in all of this is just how critical it is that individuals empathically and openly listen to one another, to understand and not merely to respond, so that potential learnings are not missed.

Carl and Fred Rogers both believed in the power that mentorship holds through teaching and learning (and had their own impactful mentors; see Flecker [2014] and C. Rogers [1995a]. In fact, psychologist Margaret McFarland, a contemporary of Erick Erikson, not only mentored Fred Rogers in life but served as a child development expert for *Mister Rogers'*

Neighborhood. See: https://www.misterrogers.org/articles/margaret-mcfarland/). Both set out, in their own unique ways and contexts, to unlock the potential hidden in others. Where Carl Rogers facilitated helping relationships directly, enabling growth in the psychotherapy client's journey of self-discovery, Fred Rogers delivered his signature expression of care through television. I strive to keep their principles alive.

Acknowledgments

I was supported academically during the period of this work by a Graduate Fellowship sponsored by the U.S. National Weather Service and awarded by the American Meteorological Society. The opinions, conclusions, and recommendations expressed here are mine alone and do not necessarily reflect the views of the National Weather Service or American Meteorological Society. Three current or former mentees, Dylan Allen, Grace Carpenter, and Aaron Serré, proof-read and provided feedback for which I am gratified and humbled. I am further grateful to H. Michael Mogil for discussion of these topics; and to several other mentors and mentees who have been influential to me over the years. Note that a preprint of this article exists at https://psyarxiv.com/c2tf9/.

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Supervision: Carl Rogers, Where are You Now?

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Abstract. *Clinical supervision for therapists in training is a requirement across the various helping disciplines. Supervision, while a common role for therapists is, at the same time, a daunting task. Among the many challenges faced by humanistic supervisors is the ability to balance the many roles associated with supervision (e.g. mentor, teacher, gatekeeper, administrator and so on) with the necessary and sufficient conditions for change as outlined by Carl Rogers which facilitate the growth of novice clinicians. The importance of the therapeutic relationship and empathy have been well documented in contemporary research, yet much of graduate training and supervision lacks the experiential component that forms the most critical elements of this therapeutic foundation. I suggest that going back to the basics of person-centered/humanistic theory in supervision is a way to ameliorate this short-coming in training programs.*

Keywords: supervision, humanistic, Rogers, person-centered, client-centered

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Supervision is one of the most basic, yet one of the most sacred tasks of a therapist. By edict, one must be supervised in various formats in every step along the way. The various helping professions share this paradigm: social workers, marriage and family therapists, psychologists and licensed counselors all share this age-old tradition of mentorship and gate keeping. In recent times, however, an idea that there is a better way to do things has obscured the basic humanistic tenets that have long been the bedrock of these diverse helping traditions.

To fully flesh out this point, a digression into the fundamental components of relationship is warranted. Whether in the role of supervisor, teacher, mentor, or parent, the importance of the relationship remains constant—"the North Star" of the discipline. Carl Rogers (1986) set this framework years ago: He stated unapologetically that in order to have a growthful relationship, two people had to be in some contact with one another. One person (e.g., the parent, therapist, or supervisor) must be in a state of congruence, while the other less so. The person in the helping role must have an unconditional positive regard for the other person—valuing them without condition, not necessarily agreeing with their action. The person being helped experiences this interpersonal dynamic and perceives the relationship as genuine. Contemporary writers continue to assert the paramount importance of the relationship, genuineness, valuing, and empathy in supervision (Brodley, 2019; Stulmaker, 2015; Metevier, 2019). This is seemingly straightforward and yet at its core it is quite complex. This complexity is at the crux of the present discussion. I would assert that inordinate amounts of time in clinical supervision (considered broadly among the disciplines mentioned previously) assisting supervisees in case conceptualization, case management, and skill development or even manualized interventions, but neglect the very foundation on which these are predicated. It is not my intent to dismiss or minimalize the value of skill sets, theoretical or otherwise, or more broadly to dismiss the inherent differences between healing professions. Rather it is my intent to return to the basics; paying attention to this neglected humanistic foundation, that is at the core of not only all helping professions, but is sin qua non to meaningful relating with others.

We have many functions as a supervisors. Contemporary supervisory theory (Bernard and Goodyear, 2009) indicate that we assume the role of teacher, therapist, consultant, administrator, and gate-keeper to the profession. I would contend that this is a somewhat sterile approach to this most important work. Raskin (2007) highlights the inherent tension between person centered theory and many evaluative and didactic tasks common in supervision. The role of mentorship is explicitly absent, but perhaps implied in some of these other roles. This seems out of order. The

various roles that a supervisor assumes should follow from the relational core or mentorship. If we lead with this, the other roles of supervision will naturally fall into place but will do so after the core Rogerian are well established as a way of being between the supervisee and supervisor. Then when a supervisor encourages a supervisee to respond more empathically toward a client, the supervision relationship will be an experiential framework which the supervisee can draw upon to help their client.

This struggle to bring graduate students into the profession is nothing new, with Rogers (1967, p. 55) leveling a sharp admonition: "We are doing an unintelligent, ineffectual and wasteful job of preparing psychologists, to the detriment of our discipline and society." It would seem that we have continued down the wrong path, but what can we do? Humanistic theory has always held experience as the hub of growth. We learn how to be caring individuals when we are cared for in early relationships. Rogerian (1992) theory blossomed in experiential formats, which harnessed the spontaneity of human interactions and connectedness. Though textbooks are technically adept at capturing the major framework of Rogerian theory, the authors often miss the experiential elements with uncanny consistency. The heart of the theory is disregarded. This is true of the work of other humanistic pioneers as well. Rogers stands in the good company of Maslow, Bugental, and Jourard to name a few. In writing, concepts like 'unconditional positive regard,' 'actualizing tendency,' 'congruence,' 'empathy,' and the like become definitional, relegated to the glossary of a textbook. Again, while technically accurate definitions have their place; standing alone, they leave humanistic theory as a form without substance. What is more, the focus tends to prematurely settle on the supervisee skill development rather than the supervisor. The supervisor has the opportunity and responsibility to share power with supervisees to the extent possible (Brodley, 2019), and in doing so foster's self-growth and understanding. Students then can go on to play an active role in self-evaluation (Stulmaker, 2015). Culp and Mannion (2011) aptly note that evaluation, presentations, rigid curricula and student passivity rarely fosters learning and growth. In short, we must focus on the student and not the technique or skill set.

This problem has been further exacerbated by trying to distill therapy down to the various factors to determine which are more critical for success than others: the common factors approach (Wampold, 2015). In particular, the findings that support the critical nature of empathy and the therapeutic alliance are reassuring on one hand, in that the elements that humanistic therapists hold to be essential and sufficient for change and growth are in fact empirically supported. Yet, on the other hand, this confirmation has created a unique challenge for supervision. Trainees are

often well versed in the common factors and will readily endorse the value of empathy and the therapeutic relationship. However, without experience there is little left but a glossary definition. The science and technique of therapy are grasped without the experiential art of human relating.

Do we model this in supervision? Again, not to dismiss the gatekeeper function of supervision; but the question is how to balance this with the humanistic tenants in a broad sense— encompassing the supervisory relationship. Can we value a supervisee who has a demonstrated weakness? Perhaps we have a supervisee who simply is not doing good work. They may take control of sessions, neglecting emotional content, jump to giving advice before they know their client, or make any of the other less than therapeutic interventions that are common with novice therapists (and some seasoned ones). If I stay true to my Rogerian roots, I should place trust in my supervisees' actualizing tendency (Rogers, 1951). There are risks when a supervisor's credibility, livelihood, and perhaps even license are at stake. Nonetheless, faith in the growth potential of our supervisee is paramount. Culp and Mannion (2011) warn that one of the detrimental assumptions to student growth is when they are not trusted to set their own course of learning. Perhaps taking a step back is warranted. The potential conflict is not as pronounced as it would appear on the surface: the supervisee's growth potential is not bound in a linear fashion as it might seem. If we value our supervisees without condition, and engender the essence of the other facilitative conditions, creativity will be enabled, allowing for growth and spontaneity to ensue.

As supervisors, it is easy to get caught in the paradigm that we must shape our supervisees to join the profession to which we ascribe. This is where the gatekeeper function is not in conflict with the basic humanistic tenets. The supervisee has an actualizing tendency that may or may not involve them being a counselor, therapist, etc. If supervisors are true to their humanistic roots, in touch with the 'prizing' that Carl Rogers (1967/1992) spoke of, the direction of supervision would not be linear in nature, but rather would be imbued with spontaneity, a process as flexible as human existence itself. Perhaps the supervisee becomes a counselor or a carpenter—it is not the supervisor's place to make this decision. Admittedly, I am in a far better place to welcome people into my chosen profession than I am to help people understand the tools needed for woodwork. At the same time, as a humanistic therapist, I am uniquely qualified to help someone recognize and follow their own path.

Make no mistake about it, the supervision relationship is nothing short of sacred. Supervisors have a great burden to bear—similar to other helping relationships, yet at the same time unique. There is a certain faith

that is needed to trust that our obligation as gatekeepers will be upheld if we hold true to our obligation to our supervisees. In essence, to lead others back to who they are, we cannot lose sight of who we are—both tasks must be undertaken without judgement and with a true fascination of our human growth potential.

One of the most basic humanistic tenets is that illness, both physical and psychological, occurs when we ignore our growth potential (Jourard, 1971). In essence, when we turn our back on our potential, we become hindered and limited. It stands to reason that this applies broadly, including to supervisory relationships. Almost as a matter of definition, when supervision becomes mired in harsh evaluation and perhaps a supervisor's anxiety about gatekeeping, growth is near impossible. The very deficits we wish to remedy become further and further from our scope of influence. A predictable pattern emerges; a supervisor becomes frustrated; a supervisee becomes more anxious—the supervisor becomes more frustrated, followed by more supervisee anxiety, and so on and so forth. At this point, creativity and growth are distant memories; shadows of a theory forlorn.

It is incumbent upon the supervisor to step back and take stock of this grim situation. In Rogerian terms, the supervisor has lost sight of the supervisee; stopped 'prizing' them at some point. We are pulled far from our center and are no longer congruent. What to do then? Let us assume that our supervisee is not committing a grievous unethical or illegal act, instead let us consider a supervisee who is struggling to adjust to the pressures of academia, one who is not sure if they can 'make the cut' in graduate school. They are wound tight and may soon snap if they do not experience facilitative conditions.

It is easy for supervisors get too caught up in the "right way." Again, we are not talking about egregious ethical violations, but rather the basic process of therapy. As a discipline, we have attempted to distill therapy down into its elemental parts. For instance, open versus closed-ended questions. Closed-ended questions are bad—really? I would argue that when therapy is condensed to a fill-in-the-blank exercise, it lacks the spontaneity to be anything but inhibiting to the therapeutic process. There is a parallel process that is imposed in supervision as well: A therapist in training 'should do . . . and not do . . .' Evaluations are often on a 5 point Likert Scale with some narrative to follow. We create a script for our supervisees to follow. We talk of empathy, unconditional positive regard, and congruence, yet we can easily fail to create these experientially in supervision.

To that end, to create such an environment of growth, self-awareness on the part of the supervisor is a critical element. The example

that follows represents a type of reflexive case study, outlined in the literature as a way of co-constructing meaning and understanding in research, clinical practice, and in supervision (Etherington, 2017; McMahon, 2014; Flyvbjerg, 2006). In essence, Etherington (2017) writes that reflexivity is the ability for us to notice our responses to others and our environment; allowing us to use these as data which informs our decisions. McMahon (2014) similarly proposes that engaging in a reflective process can lead to an integration of personal and professional knowledge, provides a frame to work through interpersonal misunderstandings, thus bolstering the working relationship in supervision. Perhaps a supervisory case example will help illustrate this more tangibly how this approach to knowing can lead us out of the tall weeds: I want to consider my work with second year doctoral student who I supervised a number of years ago. For illustrative purposes, let's call him Mike. He requested to learn more about humanistic therapy and requested to work with me to this end. Mike's style in therapy was not typical and could even be a bit off-putting at times. He could be quite terse with clients, yet clients returned week after week. Outcome measures of therapy showed that Mike's clients improved, and both open-ended questions and Likert scales indicated that Mike's clients felt 'listened to,' and rated both Mike and their work in very favorable terms.

He was 'off script' for sure. Fortunately, in a moment of clarity I shifted my focus to curiosity instead of judgement. I enlisted the help of Mike in this process of discovery. I became intensely fascinated by his life story; what had led him to this point and what made him want to be a therapist. His strong interest in the humanistic/existential framework was forged from significant turmoil in his own life. He brought himself to sessions; he was being congruent and spontaneous in his work with clients, but this did not fit the mold of typical therapists. One of the free response answers on a client evaluation kept coming back to me: "He really appreciated who I was and helped me to see my own value." That is what good therapists do, enter fully into relationship with clients (Lambers, 2000)! This was almost squashed by me, a supervisor who ascribes his theoretical stance and general way of being in the world as humanistic, heavily influenced by the work of Rogers, Maslow and Jourard. It was my turn to take a seat on the steps and take stock of my approach to the work at hand.

I decided to take a page from the works of Jourard (1972) with respect to self-disclosure. Jourard noted that therapists should not ask clients to answer any questions which the therapists were not willing to answer themselves. Taking the liberty to extend this to supervision, I decided to share my dilemma with Mike. I explained in some detail the struggle I was having as his supervisor and my fears that I could unwittingly

stifle his growth both in professional and personal realms. I enlisted his help in making me aware of times when I may be encouraging him to fit the 'therapist mold.' I encouraged Mike to watch some video of my therapeutic work and to give me feedback in the hopes of making the supervision relationship a bit more egalitarian. I also requested that he ask me pointed questions about how I do therapy and why I might say the things that I do in sessions and contrast this with how he would approach the work.

Some may accuse me of blurring the supervisory roles. Admittedly, I was 'off script'—but that was precisely where Mike and I needed to be. I did not lose sight of my evaluative capacity, my power in the relationship, or any of the more mundane administrative tasks. More importantly, I was 'getting' Mike, and he knew this. As time went on, ironically, some of his sessions started to fit the 'mold' and others did not, but this was part of his growth process. Interestingly, my sessions with clients took some detours from the "mold." He and I laughed at our folly and celebrated our success with clients and with each other. His freedom to simply be in a relationship with his clients and with me was remarkable. He grew, and admittedly, I did as well.

So what can be learned from this example? Well, I will attempt to highlight a few of the more pertinent points that are evident to me, but there are undoubtedly other lessons interwoven in the story. First, even seasoned supervisors, are susceptible to losing track of the necessary and sufficient conditions for healthy growth. It may even be that the more seasoned a supervisor, the more likely it is for this to occur, but I digress, as this is likely a topic for another paper. Secondly, a supervisor would do well to enlist the assistance of their supervisee in the supervision process, when things are going well, but most importantly when things are not. This allows for a recalibration, of sorts for both people in the dyad and harnesses the co-construction of meaning and experience of which Etherington (2017) wrote. The even better part, in my opinion, is that this mutual process energizes the supervisory relationship, making it an experience. We model vulnerability by being vulnerable. We make it OK to be confused, frustrated, or the like. We model how to move toward these experiences, trusting the process, instead of recoiling and becoming defensive. The parallels here between supervision and therapy are apparent, but worth highlighting nonetheless. What better way to teach an aspiring therapist how to be present with a client than to be present with them in supervision.

The final point we wish to make is the significance of creativity. Recognizing when we are 'off script' can be a barometer for creativity. If we are sitting with a client, a supervisee, or any other person for that matter, and we are doing everything as we have in the past with other people with

no deviation, there is no creative process. This is almost a matter of definition—if we are mired in the past we are not present. To offer specific suggestions here would be a comedic error—there is no task list for creativity or spontaneous human relating. However, if I were to hazard a prescription for supervision that has stalled, it would be to do something different. Force yourself 'off script,' experiment with a novel way of being with the supervisee and encourage them to help out with this. At the very least you may end up with something to laugh about. It can be freeing to not take yourself so seriously, whether you are a supervisor with decades of experience, or you are a novice seeing your second client ever. It is normal to get caught in roles, with exhaustive lists of what we should or should not do. There are extensive measures for how things ought to turn out, checklist upon checklist. It is, however, extraordinary to really connect to and understand another person—why wouldn't we want to share this with our supervisees?

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The Development of Additional Propositions of the Actualising Tendency: Person-Centred Theory and Practice

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Abstract. *This paper discusses the actualising tendency in order to clarify meaning within Rogers' original presentation of the concept, and outline additional propositions to advance contemporary thinking regarding theory. The paper aims to discuss the research which led to the development of the new propositions and recount the fundamental theoretical underpinnings for each proposition. Possible applications for practice are then discussed alongside opportunities to further this research. The additional propositions are consistent with the guiding principles of person-centred theory and demonstrate the potential for contemporary reinterpretations of Rogers' original work for person-centred therapists.*

Introduction

The actualising tendency is one of the fundamental tenets of the person-centred approach. Rogers first introduced the theory of actualisation in his book Client Centred Therapy (Rogers, 1951), where he presented the nineteen propositions of person-centred theory, of which the actualising tendency was number four. Finke (2002) highlights how essential this concept is for many practitioners, largely defining their attitude to the therapeutic process. With Bazzano (2012) stating 'trust in the actualising tendency is akin to faith in the unknown' (Bazzano, 2012, p. 140) further highlighting that 'by rooting the person-centred approach on a fundamental trust in the actualising tendency, Rogers firmly inscribed person-centred philosophy within the phenomenological tradition.' (Bazzano, 2012, p. 142).

The purpose of the study which this paper is derived from was to consider the relationship between suicide and actualisation within person-centred theory, while additionally exploring the theoretical underpinnings of the actualising tendency itself and how it sets out to explain what Rogers (1951) termed constructive and destructive behaviour. Rogers (1951) stated

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'The organism has one basic tendency and striving - to actualise, maintain and enhance the experiencing organism' (Rogers, 1951, p. 487) thus centring the actualising tendency as constructive. Current theoretical commentary discusses if destructive behaviours, such as one breaking the law, can amount to an individual actualising (Brodley, 1999). However, research that discusses whether suicide can be included within the scope of destructive behaviours is limited with Simanowitz and Pearce (2003) stating:

'There are, of course, examples of people who cannot escape from self-destructive behaviours, which often means they cannot become clients or benefit from counselling. Sometimes, sadly for these people, dying is the alternative to actualizing.' (Simanowitz & Pearce, 2003, p. 52).

In order to understand this area further a research sample of suicide notes, taken from Schneidman and Farberow (1957) and Etkind (1997), were analysed, firstly using stanza analysis followed by a narrative analysis, with a focus on understanding why individuals had chosen to end their life. On completion of the data analysis it was noted that proposition four on its own did not provide enough information for the narratives to be analysed in relation to it. Therefore, following a review of the literature on the actualising tendency, additional propositions were developed to encompass more of its fundamental principles and the notes were further analysed on that basis; this paper presents those additional propositions.

Firstly, this paper will explore the background to this research and offer a review of the literature on the actualising tendency, including contemporary developments. An overview of the original study follows explaining how the additional propositions were developed; these additional propositions are then presented. Lastly, potential applications to counselling practice are considered, followed by opportunities for further research.

Background and Review of the Literature

Rogers (1951) highlighted that the actualising tendency was the sole motivational concept and formed part of the basic functioning of an organism. Others have since described this tendency as being either fundamental (McMillan, 2004), there to protect life (Merry, 2002), or ever present within human experiences (Brown, 2015). Finke (2002) highlights the essential nature of the concept in defining many practitioners' attitudes toward the therapeutic process.

Through reading Rogers' work on the actualising tendency, it is clear that definitions and terminology have changed over time. Indeed, Ford and Maas (1989) highlight inconsistency in the ways the actualising

tendency is defined, associating this with a lack of understanding of historical shifts in terminology. They outline the changes made between Rogers' (1951) conceptualisation of the actualising tendency, which was termed self-actualisation, and Rogers' (1959) later explanation which now includes the actualising tendency and self-actualisation. Rogers (1959) stated that self-actualisation is a secondary tendency, which follows the development of self and exists to maintain that self. Unlike the actualising tendency, self-actualisation does not necessarily indicate that an individual is functioning at an optimum level, instead it suggests that, regardless of wellbeing, the individual is in the process of self-actualisation, in order to maintain the self (Ford & Maas, 1989). Bozarth and Brodley (1991) explain this further, stating actualisation of the secondary tendency, can become discrepant from organisms, in unfavourable conditions. Under favourable conditions the actualising tendency and the sub-system of self-actualisation are harmonious (Bozarth & Brodley, 1991).

Rogers (1980) states in relation to life's directional process,

'We can say that there is in every organism, at whatever level, an underlying flow of movement toward constructive fulfilment of its inherent possibilities' (Rogers, 1980, p. 117).

Rogers (1980) clarifies that this is present in all living things, including human beings. Throughout his work on the actualising tendency he offers examples within nature, including potatoes (Rogers, 1951), sea urchins (Rogers, 1980), seaweed and dinosaurs (Rogers, 1963) (although he recognised the latter were part of their own downfall). Commentators such as Finke (2002), state that these biological examples of self-regulation are useful for illustrative purposes but should only be viewed as metaphorical. However, for Rogers (1980) the organism, including human beings, can be trusted to behave in a way that is directional towards the maintenance, enhancement and reproduction of the organism.

Rogers (2004) outlined some of the behaviours of his clients which he believed, were a result of the actualising tendency. These behaviours included recognising their true self and moving away from meeting expectations, 'oughts' and pleasing others (Rogers, 2004). Instead they moved toward self-direction, complexity, openness to experiences and trusting the self (Rogers, 2004). Rogers (1989) summarised these behaviours as the ability to simultaneously experience life and experience feelings without the need to block them from awareness. On this basis, individuals can act on what they feel is right and, by trusting this, the resulting behaviours will be satisfying ones (Rogers, 1989).

Rogers (1962) highlights his belief that the behaviour demonstrated by human beings is rational and this behaviour, in its subtle and complex way, enables the organism to move toward its chosen goal. The actualising tendency is, therefore, selective, and also constructive inasmuch it 'does not actualise its potentiality for self-destruction, nor its ability to bear pain' (Rogers, 1963, p. 6). It is stressed that only in perverse or unusual circumstances is the potential for these aspects actualised (Rogers, 1963). Rogers did not, however, go on to clarify what perverse or unusual circumstances might be.

Contemporary Developments Of The Actualising Tendency

Illogicality Of Conditions Of Worth

Based on these views proposed by Rogers (1962, 1963, 2004), it is suggested that self-actualisation, not actualisation, is the only explanation for suicide and other 'destructive' behaviours. However, Merry (2008) highlighted through his comments on the illogicality of conditions of worth how an apparent destructive behaviour can, in fact, be constructive if it protects the individual from damage or hurt.

Merry (2008) stated that the formation and presence of conditions of worth are indicative of an individual's incongruence. However, as the actualising tendency is the sole motivational tendency, these conditions must be an expression of this (Merry, 2008). This logic seems inconsistent, particularly given that conditions of worth are often viewed as having a destructive impact on the individual (Merry, 2008). But, if conditions of worth can be viewed as acting to benefit the individual this 'inconsistency' is resolved (Merry, 2008). For example, one might supress anger as an unacceptable characteristic that may lead to a withdrawal of love from others. The individual's potential to express their feelings in that moment was dismissed. However, the higher risk of not being loved was neutralised by the behaviour resulting from the specific condition of worth (Merry, 2008). This thinking is supported by Brodley (2019) who states that one assumption or belief of the person-centred approach is the 'belief that persons are realising and protecting themselves as best they can at any given time and under the internal and external circumstances that exist in that time' (Brodley, 2019, p. 40).

Merry's (2008) thoughts support those of Brodley (1999), who discusses how behaviour, which could be considered evil, is still being constructively directed by the actualising tendency. Brodley (1999) provides an example of so-called honour killings of females within some cultures. In such circumstances the individual's conditions of worth direct

the behaviour away from value of right to life, in order to maintain love and social standing within their community (Brodley, 1999). Scholars such as Kim (2018), later discussed the importance of recognising specific and unique cultural influences that may impact an individual within circumstances, like those demonstrated by Brodley (1999). Brodley (1999) explains that this behaviour may not be seen as constructive within many cultures, however, recognising the actualising tendency's ability to maintain and defend the self, Merry (2008) provides an explanation for seemingly destructive behaviours within person-centred theory and the conditions of worth. In relation to Rogers' (1963) thoughts on the constructive nature of the actualising tendency it can be assumed that some instances of other seemingly destructive behaviours such as suicide may have the potential to be viewed as constructive by the individual.

Pluralistic Perspectives

Another relevant development in person-centred theory, in relation to the actualising tendency, is Cooper's (1999) proposed model of plurality, which seeks to explain the seemingly different 'selves' clients discuss during counselling. Cooper (1999) theorises that when an individual is presented with an experience which is discrepant with their self-concept, they may either deny or distort it, as Rogers' (1959) theory would state, or they create a new self-concept which allows this experience into awareness. For example, developing a self-concept that allows for anger rather than the calm state they usually experience (Cooper, 2013).

Alternatively, recognising Cooper's (1999) work on plurality and Warner's (2000) work on disassociated process, Mearns and Thorne (2000) discuss their theory of configurations of self, which seeks to explain their clients' tendency to label different parts of themselves. Merry (2004) explains that these configurations allow the individual to be flexible to their circumstances, and to combine different values, attitudes and personal characteristics depending on the appropriateness of the context whilst maintaining a consistent self (Merry, 2004). Ultimately, within these different configurations, Mearns and Thorne (2000) recognise that some have a tendency for growth and others do not.

Despite Mearns and Thorne's (2000) recognition of Cooper's (1999) plurality theory, Merry (2008) believed that the two were distinctly different in that Mearns and Thorne's (2000) configurations of self does not involve an individual having multiple self-concepts. This is more in line with personality theory within person-centred theory, which highlights the importance of a single self (Merry, 2008). Cooper (2013) however, states that Rogers (1959) was not against the idea of a plural self, with Merry (2008) concluding that 'the various 'configurations of self' demonstrate the

creativity and flexibility of actualisation' (Merry, 2008, p. 52) therefore different qualities can be called upon by the self in different situations. And, as previously mentioned, if the actualising tendency seeks to actualise the individual's potential of self-defence then the theory of the actualising tendency is consistent and logical and the theorising of multiple self-concepts is not required (Merry, 2008). Based on Merry's (2008) conclusions, it is possible to suggest that seemingly destructive behaviours such as suicide, are an example of an individual actualising their self-defences within a specific configuration of self.

The Actualising Process

Mearns and Thorne (2000) point out that Rogers' (1959) explanation for disturbance within the individual occurred because the actualising tendency conflicted with self-actualisation or, as Merry (2008) explains, with itself, as self-actualisation is a sub-system of the actualising tendency. Mearns and Thorne (2000) propose that disturbance is conflict between actualisation and environmental factors; influences that are not simply parental introjections, although they may play a part (Mearns & Thorne, 2000). This disturbance, known as 'social mediation', is termed the actualising process (Mearns and Thorne, 2000) and its importance is highlighted by Mearns (2002), who recognised it through a new proposition within a person-centred theory of self.

Mearns and Thorne (2013) recognise Brodley's (1999) statement that the actualising tendency is a pro-social tendency and cite Rogers' (1951) minimal comments on socialisation as reasons for revisiting this element of person-centred theory. They state that the growth process is only able to progress following recognition of the impact of social contexts, such as having others in one's life (Mearns & Thorne, 2013). These contexts may provide the basis for growth in future, and therefore would be recognised in the moments of potential growth (Mearns & Thorne, 2013). An example from a client might be the opportunity to take a new job which would involve a family move to another country. The actualising process seems to provide a construct with which to understand the potential conflict between the actualising tendency and the client's environment.

This proposition situates the individual within their environment and recognises how the individual both shapes their environment, and how they are shaped by it (Merry, 2008). It also recognises how the actualising tendency may operate to protect the individual from hurt by prioritising the social space in which it occupies (Merry, 2008). However, Merry (2008) emphasises Mearns and Thorne's (2000) language in relation to the actualising tendency whereby they refer to the actualising process allowing

the actualising tendency to express itself to a certain degree. Merry (2008) states that the actualising tendency does not have the ability to operate at a certain degree, it is only able to operate fully at all times (Merry, 2008). The existence of any inhabitation is thereby only further evidence of the actualising tendency as it works to not only enhance the self but also to defend it (Merry, 2008). This thinking may provide another perspective with regards to risk and the actualising tendency.

Overview of the study

The focus of the research was to explore whether suicide could ever be an expression of the actualising tendency or whether, as a form of 'destructive' behaviour, it could only be viewed as self-actualisation. A further objective of the study was to gain an understanding of how this could affect the counsellor's work in relation to ethics, with a particular focus on the principles of autonomy and non-maleficence within the British Association of Counselling and Psychotherapy (BACP) (2018) Ethical Framework. This paper is focused on the development of the additional propositions which developed from this research.

Development of the additional propositions

When analysing the data, it was concluded that the proposition on the actualising tendency did not provide enough clarity in relation to the narratives identified within each suicide note. In addition, it was also noted that the original presentation of the actualising tendency did not encompass all of the fundamental principles and limited the researcher's ability to establish whether the explanations for an action, suicide being one example, could have the potential to be considered an expression of the actualising tendency or not. More precisely, Finke (2002) highlighted the need for the actualising tendency to be operationalised in order for it to '…be useful with for practical applications…' (Finke, 2002 p. 29). The experience of conducting the research informing this article seemed one such practical application. Therefore, through interpretation of the theory, possible additional propositions were suggested, and each completed suicide note was analysed based on these propositions, which enabled some conclusions to be drawn.

The Propositions

The following framework is based on the fundamental principles of the person-centred approach and are explained as follows:

1. The chosen action is self-directed. Rogers (1959) highlighted that a characteristic of the actualising tendency was the individual

'moving towards autonomy away from heteronomy, or control by external forces' (Rogers, 1959, p. 196).

2. Within the individual's perceptual field, the action can be viewed as constructive.
    a. The action maintains or enhances the organism (up to the point of death if appropriate)
    b. The action may have a positive overall evolutionary impact
    c. The action could be viewed as problem solving in nature

    This proposition as a whole underlines the phenomenological positioning of the actualising tendency and allows for the acknowledgement of individual cultural factors/influences such as gender, race, religion, and community (Kim, 2018). Alongside this, part a) is in line with Rogers' (1951) propositions of his theory of personality. In addition, as the actualising tendency is the primary tendency, Brodley (1999) and Merry's (2008) conclusions - regarding behaviour that acts in self-defence or to maintain the self being an expression of the actualising tendency rather than self-actualisation - is also applied here. Part b) refers to Rogers' (1980) statement that the actualising tendency serves to reproduce the organism. The inclusion of the positive evolutionary aspect accounts for this reproductive element in a similar way to perhaps those who choose not to reproduce for the greater good of the human population. It is a constructive decision for evolution to not reproduce or affect the population that remains in a detrimental way. Part c) references Brodley's (1999) point regarding trusting in an individual's actualising tendency to discover constructive ways to solve their problems.

3. Any action which actualises the potential to bear pain or act self-destructively is under perverse or unusual circumstances.
    Rogers (1963) stated in reference to the organism, '…nor does it actualise its potentiality for self-destruction, nor its ability to bear pain. Only under unusual or perverse circumstances do these potentialities become actualised.' (Rogers, 1963, p. 6). Rogers (1963) does not define or explore what these circumstances might be, however in line with the phenomenological basis of person-centred theory it is reasonable to suggest this is viewed from within the individual's perceptual field.

4. Receiving the core conditions in therapy or otherwise would not have affected the individual's action. Rogers (1980) highlighted that by providing the core conditions a positive directional tendency

> would occur. If, by receiving the core conditions, the individual's chosen course of action may have been affected, this may provide an insight into whether the chosen course was self-actualising rather than actualising.

As previously stated, the development of the above propositions enabled the research informing this article, which explored the relationship between suicide and the actualising tendency, to continue. Without them the research would not have been able to come to any informed conclusions, no matter how tentative. The propositions provided a framework within person-centred theory to engage with the stories told by individuals that allowed for a greater understanding within the fundamental principles of the person-centred approach. Although this research was based on the act of suicide, there may be opportunities to use these propositions to understand other behaviours or actions, both seemingly destructive and constructive.

Potential Application To Counselling Practice

Reeves (2015) highlighted the importance of using supervision when dealing with risk, enabling the client work to be explored fully. Using the additional propositions of the actualising tendency may provide a structure within person-centred theory in which to discuss the client. Additional models of suicide or recognition of specific individual risk factors could potentially be used alongside this, but the use of the propositions may offer support in maintaining a person-centred supervisory conversation, if so desired. In a similar way they may be useful to discuss any behaviour or actions that initially appear destructive not just those related to risk, such as the example of so-called honour killings highlighted earlier (Brodley, 1999). Brodley (1999) discussed how behaviour which may be considered to be destructive or evil is still being driven by the actualising tendency and is therefore essentially constructive. In addition, there was a recognition of the perceptual field and culture in the case of honour killings, when understanding how this behaviour could be considered constructive (Brodley, 1999, Kim, 2018). Despite the moral position that many counsellors may take in regard to this example, the application to the actualising tendency is still valid with Brodley (1999) stating 'Many people are unlikely to recognise the constructive drive or pro social tendencies in 'honour killings'. Nevertheless, wrong as this practice seems to many of us, the behaviour in part expresses the actualising tendency and pro social human nature' (Brodley, 1999, p. 114-115).

The BACP Ethical Framework (2018) is clear that confidentiality can be broken if permitted by the client or by law. What is less clear, is the criteria to establish if the client's current risk is 'enough' in order to do so.

Principles of autonomy and non-maleficence within the BACP Ethical Framework (2018) may be particularly relevant here. The first highlights the client's right to self-govern and the latter the counsellor's commitment to avoiding harm to the client. The practitioner has the task of making the decision that strikes the 'best' balance between these principles. A supervisory discussion utilising the propositions as outlined above may enable a clearer understanding in relation to these principles, before a decision to break confidentiality is made.

In this regard, Reeves and Mintz (2001) discussed the possible impact of counsellors' views about suicide on client work with regard to confidentiality, noting that counsellors who believed in a client's right to make an individual choice felt greater uncertainty about when to break confidentiality, and those who were clearer on breaking confidentiality were more likely to personally disagree with suicide. Potential use of the newly proposed propositions of the actualising tendency may enable continued development of understanding. It may also potentially provide the counsellor with increased clarity regarding their own beliefs and enable them to separate these from the views and beliefs of the client.

Furthermore, Reeves (2018) notes the willingness of practitioners to favour the use of questionnaires to assess risk rather than verbal communication. It may be possible that the newly formulated propositions would allow practitioners to understand this behaviour the same way they would any other, given the lack of support either philosophically or empirically that the act of suicide is principally different from any other act (Szasz, 1986). Reeves (2018) acknowledged the desire, as a practitioner, to want clients to be safe, but also acknowledges how tools aimed at predicting risk, can be inaccurate (see for example Large, Kaneson, Myles, Myles, Gunaratne & Ryan, 2016). This reinforces the importance of dialogue between counsellor and client. It also underscores that having a specific person-centred 'tool' (such as the newly formulated propositions) for person-centred counsellors to consider with regard to their clients, would perhaps bolster them to continue discussing the nature of risk.

One example from the study is the following suicide note:

Dear Mary. You have been the best wife a man could want and I still love you after fifteen years.

Don't think to badly of me for taking this way out but I can't take much more pain and sickness also I may get to much pain or so weak that I can't go this easy way. With all my love forever-

Bill

(Schneidman and Farberow. 1957, p. 203)

It seems that what Bill is saying is that his decision to end his life is a self-directed one (Proposition One), and within his perceptual field it could be considered constructive as he would no longer be in unbearable pain (Proposition Two). From the researcher's interpretation, it was reasonable to say that Bill was in perverse or unusual circumstances given the context explained in his note, (Proposition Three) and it did not seem that this would be affected whether he received the core conditions, in therapy, or elsewhere (Proposition Four) (McGarry, 2018).

Overall, the propositions of the actualising tendency outlined within this research, which include recognising the individual's perceptual field, may provide additional support to a counsellor when dealing with material that is particularly challenging. Clearly, further research is required to attest to any of the tentative assertions made here.

Opportunities For Further Research

This research revealed many areas for further study in relation to both theory and practice. From a theoretical perspective, there appears to be a lack of commentary on what can be deemed as unusual or perverse conditions, in relation to the actualising tendency (Rogers, 1959). It may be useful to have more commentary on this to support counsellors in their client work. There also seems to be a lack of discussion about suicide as it relates to person-centred theory and practice. The language of 'destructive behaviour' (Rogers, 1959), of which suicide may be considered, may be based on the judgement of others rather than the client. If this is the case, it would seem to contravene the fundamental principles of the person-centred approach. However, if all behaviour is indeed directed by the actualising tendency (Merry, 2008), then given its goal orientated nature, the words constructive or destructive may not be necessary.

In terms of the definition of the actualising tendency, it may be timely to revisit the fundamental element of the theory related to evolution. It seems reasonable to state that individuals have far more choices, regarding both life and death, at this juncture in history than during the 1950s when the theory was developed. For example, with regards to having children more individuals now choose to remain childfree for a variety of reasons (BBC, 2010), and those who travel abroad to receive assistance to die demonstrate more agency over their death (The Guardian, 2009). Both decisions on the surface, would appear to be 'anti-evolutionary'. Therefore, further research may be needed in order to understand these choices within the boundaries of the theory of the actualising tendency.

Finally, in relation to risk, from a practice perspective there may be an opportunity to understand whether those working from the person-centred perspective would be more willing to continue with dialogue rather than moving to risk assessments, as pointed out by Reeves (2018). If person-centred practitioners are able to utilise clarified propositions of the actualising tendency, such as those developed within this research, they may provide a framework for dialogue with clients that is in line with a more relational approach. If risk assessments continue to be as inaccurate as they currently are (Large et al, 2016), and government policy, such as that in the UK, continues to centre around a prevent agenda (Department for Health, 2012), it seems the responsibility on counsellors to work 'well' with risk will continue.

Conclusion

Brodley (2019) explained that Rogers envisioned his theory would be tried and tested and one that '…could be used as a basis for further research on psychotherapy.' (Brodley, 2019, p. 37). It is on this basis that the presentation of the additional propositions of the actualising tendency are offered. They were developed from the ground up, based firstly on the fundamental principles of person-centred theory and then advanced with contemporary research-based thinking focussed on 'destructive behaviour' as identified by Rogers (1959), namely suicide. These propositions offer a meaningful contribution to person-centred theory and practice and an additional starting point for further research on psychotherapy.

Acknowledgments

Some of this work is derivative of my Master's Dissertation and is snapshot of the overall analysis and theoretical considerations. McGarry A. Exploring suicide potential and the actualising tendency: A qualitative study of suicide notes. (Unpublished dissertation, 2018).

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The Effect of Person-Centered Theory for Clinicians with Hard Science Favor

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I was very skeptical going into the conference. I had come from an educational background of the hard sciences and also with a very heavy interest in research. I found myself aligning with theories such as CBT and the work of Ellis and Gestalt. I am also going to be completely honest and say that I did not have much faith in person-centered theory and took the class merely as a way to earn some credits. I also thought it would be interesting to experience what others opinions upon the matter were. I was pleasantly surprised by the wealth of information that I am taking away from the person-centered conference. The conference was very informative between the lectures and the sharing of experience and knowledge with professionals in the field. Also, the conference presented the concepts and frameworks of person-centered therapy in action. It is safe to say that by attending the conference I have gained much more insight and knowledge for future practice. My eyes are now opened to the thought and power of person-centered.

There are a few concepts that I would like to break down and express what I have learned through the conference. I find that some of these concepts are very useful in a wide range of practice. Similarly, they also have use for a diverse range of clients. The information gathered from the conference has made a significant impact on myself, so much so that I can imagine using them in future practice. I want to express, once again, the wealth of information that I have gathered from the conference and note that this paper only begins to scratch the surface of my experience.

The first concept that I want to discuss is goal setting for our clients. As I have mentioned I have had vast experience in the hard science field. This means that I have had strict and measurable goals set for each client or case that I have been a part of. Before the conference, I had a sense of security with set goals due to the ability to measure my success after completion. This idea paralleled into counseling for me as well. With such theories as CBT, I would again, have trust in the determined and measurable goals, for example, symptom/irrational belief reduction. According to Carl Rogers, one of the goals of therapy is for the individual to become a fully-functioning person. A fully functioning person has a better sense of

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awareness and value. This person may also experience a more comprehensive and fluid environment and match that with their mental processes (Rogers & Koch, 1959).

I find this idea of the fully-functioning person to be quite intriguing. I experienced this idea during the conference when individuals would share their experiences. It was inspiring to see other professionals simply be there for that individual and let them experience whatever they may have needed at the moment. I realized that while the safety net of a strict framework was missing there was also a level of comfort that filled that space. The individual was not set on meeting certain standards to be "okay" or worried about their responses and what that could mean for their progress. They were granted a space to be themselves and experience their reality however they needed.

With this realization, the individual could hone in on themselves and their awareness. With this ability, the client also has the opportunity to gain accountability and power. They are taking charge of their journey and that is a big factor in client outcome.

The next concept that has been on my mind is the 6 core conditions which are necessary and sufficient to allow personality change for the client. The six core conditions are as follows:

> 1. Two persons are in psychological contact.
> 2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
> 3. The second person, whom we shall term the therapist, is congruent or integrated into the relationship.
> 4. The therapist experiences unconditional positive regard for the client.
> 5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
> 6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved (Rogers, 1957).

The conditions mentioned hold a lot more meaning than I had previously thought. More specifically, empathy, unconditional positive regard, and the congruence of the therapist were conditions that I had heard of before but did not truly understand their depth until the conference. Along with my classmates, I'm sure, I have heard the word empathy used in every single class thus far. This word has been the tried and true method for counseling across the board. In a book written about a similar theory,

empathy is discussed concerning an individual's ever-changing emotion and experience.

"Of crucial importance … is the recognition that all the client's processing operations occur in the present and that the therapist's attention needs to be focused in a fully absorbed manner on the client's present experience and expression. The therapist attempts to hear, see, and understand clients as they are at that moment and to stimulate experiential processing rather than attempting to formulate hypotheses about clients' internal dynamics or to change or modify clients' cognitions or behaviors" (Greenburg, Rice, & Elliott, 1993, p. 3).

The quotation states the maintenance required with true empathy and also helps to depict what a positive therapeutic environment could look like. With the combination of the information read and the experience from the conference I think I have a much better understanding of the true meaning and work that must go into being an empathic counselor.

During the conference, there were many different situations that groups were utilized and individuals could speak openly about whatever they desired. It was during the event that an individual would share something personal that I had the opportunity to observe true empathy. Empathy is not just understanding what the person is telling you. It is much deeper than that. Empathy is finding those deeper meanings and helping the client to comprehensively understand themselves and the effects of the experiences. To see a counselor simply provide a space for someone but also understand the true deeper meaning behind it was fascinating. Also, there were many times that an individual would state concern or belief which would be revisited after some time had passed. The individuals were not necessarily questioned about their statements but rather their thoughts and feelings after some time to process. It helped resonate with the power of empathy and exemplify its proper use.

Lastly, I would like to touch base upon the mechanics of the conference so to speak. The format of the conference was very lax. There were structured lectures and set times for meetings but in actuality, they were loosely enforced. To be transparent, this was difficult for me to process at the beginning. I did not understand how everyone could be so relaxed. This was not very Rogerian of me. As time passed I made the connection as to why this played out the way it did.

In a lecture given by Carl Rogers, he spoke largely about education and the teacher-student relationship. In the video, Rogers placed much more emphasis on the relationship shared and the individual learner versus the

course material itself. Rogers states “I want to think and learn for myself and I can’t get that out of a textbook or mechanical teacher persona” (Rogers, 1957). I think that this quote exemplifies Rogers's mentality very well. This mentality is also then seen in his client-centered theory.

To return to the schedule and layout of the conference, I think that the previously mentioned mentality is the source of the lack of structure. Rogers did not believe in a controlled or planned out course of action because he did not believe that a client can learn from that to the extent that they can learn from themselves. Rogers believed in the power of the client and their relationship to others which is exactly what the format of the conference encouraged. As I mentioned earlier I was very uncomfortable in the beginning and I think that this is partly because I was uncomfortable with myself and my abilities as a counselor. As time when on and the material covered helped me to gain more knowledge, I became more confident. I was comfortable sitting in silence and not having control over the direction of conversation (for the most part). I think that by experiencing this breakthrough myself, I have learned the impact of the Rogerian way.

I am an individual who came into this conference fairly skeptical with baseline knowledge about Carl Rogers, at best. I have learned so much from the professionals in attendance at the conference, my peers, and the class material. Most importantly I have learned a lot from myself. I now have a much deeper understanding of Client-Centered Therapy and can confidently proclaim its potential in my future practice. I would like to thank everyone who made this discovery possible to me, but most importantly I would like to thank Dr. Cohen for giving me the opportunity that has and will continue to impact me for a very long time.

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Questioning Psychology: Beyond Theory and Control

Brian E. Levitt

PCCS Books

Monmouth, UK, 2019.

In his recent book *Questioning Psychology*, Dr. Brian Levitt takes the reader on a personal and intellectual journey through the field of clinical psychology and mental health practices. His fundamental question asks what gets in the way of our understanding other people? His response to this question examines myriad barriers to understanding including the pathologizing of suffering and distress; reductionist diagnostic practices used in assessing persons; and failure to educate practitioners to question all orthodoxies. He asserts that scientific knowledge can only move forward through constant challenge and leaps of imagination. Levitt states "From my perspective, I am just a Jew who loves to ask questions—questions upon questions. I am uncomfortable when questions are not permitted."

Levitt's debt to his intellectual elders including Carl R. Rogers, Gary Prouty, Barbara Temaner Brodley, Thomas Szasz, Jung, and Freud is evident in his defense of subjectivity as an essential aspect of understanding, and the difficult task of self-examination and self-understanding. He begins his essay with a review of the power of belief systems and presents his subversive feminist interpretation of the story of Adam and Havva (Eve). Where, he asks, would we be without Havva's disobedience? Levitt brings to this work a deep interest in Jewish history and traditions, an appreciation of diverse cultures and literatures, the evolution of science from Newton to Einstein and the profound turning point of learning that the acts of observation are affected by the observer. He also writes from his perspective as a clinical scientist, and from living life as a gay, Jewish man. In this regard, Levitt's openness about his own struggle with understanding and learning about his own prejudices and stereotypes encourage the reader to embark on examination of our own inner killer (The killer in you is the killer in me). I might add that the last four years have certainly brought that aspect of American citizenry into a tighter focus.

Levitt has the breadth and depth of training as both a scientist and an active clinician to mount a strong, persuasive critique of clinical psychology and social work. Levitt urges practitioners of all stripes to question all ideologies, including our own person-centered and humanistic framework. On one hand, Levitt defends the practice of scientific inquiry, thus aligning him with the project of finding stable patterns in the data,

advocated long ago by Carl R. Rogers and his colleagues. On the other, his chapter on the development and use of psychological assessment instruments illustrates the limits of belief in commonalities, of using a "paint-by-numbers" approach to understanding personality and human behavior.

Levitt describes what a meaningful and respectful process of assessment and evaluation can look like based upon his many years practicing in hospital settings, the courts, nursing homes and with individuals in distress. He ably describes how he honors the persons' fears that they are "crazy" or "out of control" with kindness and humility and sincere presence. This takes time and patience, and he argues, and an egoless mindset that goes beyond the numbers, allowing him to plumb the context and personal meanings of the other. If you are a student who is pursuing competence in testing and evaluation, this chapter is the most articulate and powerful critique I have seen in my own experience of 30 years teaching clinical psychology. I urge those of you who are educating graduate students who administer these instruments to read this chapter and assign it every term for the foreseeable future. It provides a powerful corrective to oversimplification and arrogant confidence in the collection of data as the final answer to assessment questions.

Levitt's provides a delicious and hilarious satire of the DSM V's diagnostic categories with his new entry called "Diagnosis Disorder." In this disorder, the "the clinician diagnoses distress experienced by other people as a mental disorder" and that the resulting diagnoses are not just theoretical descriptions but instead are true things, in and of themselves. Other criteria state "The clinician is uncomfortable engaging in "treatment" without the diagnostic label, and the clinician treats the diagnosis and not the person. This new diagnosis includes the specifiers, and ratings of severity typical of the DSM. I found it compelling and hilarious at once. This chapter alone is worth the price of this book!

But Levitt also probes the deep problems of this ubiquitous practice in clinical psychology involving "conceptualizing the client." This was a standard requirement in our professional psychology school in Chicago which Levitt attended. The tests of "clinical competence" required the student to construct a diagnostic picture of the person including the cultural, social class, racial, gender, and sexual orientation factors which positioned the client in the social class structure. I think Levitt would agree with me that these conceptualizations were basically elaborate fictions which encouraged students to categorize and classify the characteristics of the client as if they were important and real. I think that unwittingly at worst

this practice tended to increase stereotypical thinking about client populations.

Levitt, by contrast, inveighs against the fear, and sometimes the numbness, that we experience in the face of the suffering of the other, and recommends nourishing the spirit with music, literature, and art. He says,

> I find myself asking how I can open my heart to intense pain and not be consumed by it, so that I can hear it and come back and tell the story as fully and accurately as possible. Without opening my heart to the other person's experience of pain and suffering, can I ever really see and understand them? Can I bear a wound to my heart and stay connected, not get lost in the moment, and not get lost over time to burnout, awash in pain and suffering? I often hear myself saying that the day I can no longer allow my heart to be scarred is the day I will have to leave this field. I hope that day never comes (p. 139-140).

The scope of this book is extraordinary. The wisdom Levitt shares is peerless. I recommend it to any reader willing to ask the big questions and face the uncertainty and ambiguity of human life.

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An Introduction to Child-Centered Play Therapy

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"The activities that are the easiest, cheapest, and most fun to do – such as singing, playing games, reading, storytelling, and just talking and listening – are also the best for child development."
~Jerome Singer

Yale University Professor, Professor of Psychology Emeritus

Child-centered play therapy (CCPT) is an approach to Person-centered Counseling that effectively blends Rogerian tenets with the natural way children communicate through play. The three core elements of Person-centered therapy are congruence, unconditional positive regard, and empathy. Axline (1947) expanded the use of these concepts to the treatment of children through child-centered play therapy. Axline writes that "play is the child's natural medium of self-expression" (1969, p. 9) providing children with a therapeutic relationship developed in a setting of acceptance, caring and empathy facilitates trust and provides the child with a safe place to explore their emotions.

The British Association of Play Therapists (BAPT, 2020) currently defines play therapy as "the dynamic process between child and Play Therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centred, in which play is the primary medium and speech is the secondary medium." The Association for Play Therapy (APT, 2020) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Play therapy is

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a commonly accepted and widely implemented approach for working with children. Play is considered an important means of communication with children.

Axline (1969) developed eight principles to be used to guide the CCPT process. These principles involved the therapist attending to the following:

1. Develop a warm, friendly rapport with the child as soon as possible.
2. Accept the child just as they are.
3. Allow the child to express themselves freely and completely by establishing a sense of permissiveness.
4. Recognize the feelings the child expresses and reflects those them back to the client in a way that allows the client to gain insight into his/her own behavior.
5. Maintain and communicate a deep respect for the child's ability to solve problems, make choices, and institute change.
6. Allow the child to lead the way in all aspects of therapy, refraining from directing the child's play in any way.
7. Allow the therapy process to develop at its natural pace without being hurried in any way.
8. Establish limitations only when necessary to anchor the therapy to reality and with therapeutic benefit that provides insight into the child's aware of his/her responsibility in the relationship.

As Axline outlines, the expectations of the therapist are specific and require a child-centered focus in order to be most effective. The expectations placed upon a child-centered therapist are high, and therapists may need to be vigilant to remain true to this approach. Different from other therapeutic interventions for children that may offer clinical guidelines that are more lock-step, CCPT requires the clinician to remain ever present with and responsive to nuances in the child's behavior and demeanor in order to provide effective clinical support.

Therapists in agency, school, and hospital settings often have multiple roles and jobs which involve interacting and/or working with children. These roles and responsibilities do not always lend themselves to the individual taking a child-centered stance and many clinicians thereby integrate clinical theories to find an approach that both suits the demands of their workplace while also honoring clients. While CCPT tenets may be integrated with additional theoretical approaches, therapists should remain aware that slipping into a more parental, authoritarian or directive approach accepted by some clinical stances undermines the integrity of the CCPT process.

For example, a behavior therapist working in a school setting may wish to integrate their behavioral approach with CCPT. Such a professional would typically work with behavior data to reward students for what is perceived as positive behaviors based on the expectations of the school setting in order to shape the child's behavior to better meet the demands of the school setting; an approach quite deviant from the essence of CCPT. Although not impossible, this integration would take some sincere and thoughtful reflection to determine which tenets from each theory should be integrated to best support the client. Therapists wishing to integrate theories should remain aware that adhering to Axline's (1969) recommendations with fidelity is important for therapists who wish to see the full benefits of CCPT.

Logistics of Play Therapy

Office/Play Room

Setting up a playroom can be fun! It can also be a challenge. When working with children, more space and resources are always welcome to enhance clinical work that supports their growth and development. When working with young clients the clinician must remember that their clients are active beings who want to move and play. As a guideline, Landreth (2012) suggests that the ideal size room for individual work would be a 12 x 15 ft space and a 12 x 25 ft space for groups. Many private practices, hospitals, and agencies have well planned space designed specifically for play therapy. However, mental health professionals who wish to implement play therapy but do not have access to optimal conditions should not be discouraged. It is permissible to utilize child-centered play therapy techniques in alternative spaces and some clinicians even have mobile play therapy kits!

In spaces ideally designed for play therapy, a small sink with cold water is available to the therapist and child. If this is not available, a bowl of water will do the trick. A counter or desk area a storage cabinet for supplies will help the play therapist keep his or her materials organized and accessible, while a white board or chalk board and furniture appropriate for children should be readily available for your clients to access during therapy. Maintaining the cleanliness of toys, walls and furniture is important for facilitating creative play and the play therapist should have a plan related to how he or she will tidy and clean toys and materials between sessions.

In particular, cleaning and disinfecting these items has recently been at the forefront of consideration for child-centered play therapists due to the recent COVID-19 pandemic. The Center for Disease Control has published "Guidelines for Child Care Program" due to the Corona Virus – 2019

(COVID-19). Following these guidelines will allow child-centered play therapists to continue offering their important services in a manner aligned with best practice (CDC, 2020).

The design of the playroom where child-centered play therapy is conducted should hold paramount the child's ability to completely absorb him or herself in the play process. Location of the office/playroom in an area with low noise pollution is also recommended to limit distractions to the child during their session. While reducing noise outside the playroom helps to keep young clients focused on the play therapy session, managing noise levels within the playroom is also important for confidentiality. Ideally, acoustic tiles can be used help to keep sound confined to the therapy room. If possible, a playroom equipped with an attached bathroom (similar to many Kindergarten classrooms) offers a convenient way to minimize distraction for young clients. If training occurs at the site, a one-way mirror and video equipment can be useful as a means to reduce interruption to the child's play process. And, last but far from least, a chair, and/or pillow or other type of seating for the therapist so that the therapist can comfortably navigate the playroom while therapeutically serving the child. As indicated at the beginning of this paragraph, this would be the ideal space.

In many grant-sponsored programs and in agencies serving impoverished neighborhoods, space is not always optimal. However, that should not discourage clinicians from implementing child-centered play therapy and/or related techniques. When space is far from ideal, privacy, confidentiality and trust become concerns the therapist should work to achieve by altering the physical space layout and/ or processes involved in play therapy. Distance between the play therapy room and waiting area provides the space needed to maintain confidentiality and facilitates the development of the client's comfort level and confidence in the process. If possible, providing a space for the adults in the child's life to wait while the session takes place is helpful. If the waiting room is in close proximity to the office, a white noise machine is recommended to provide an audible buffer between the client and therapist and guardians in the waiting space. In the beginning stage of therapy, children often ask if their adults can hear what they are saying. The therapist should take this opportunity to build rapport and reassure the child that their privacy has been considered and accommodations have been made to maintain confidentiality. If space is not available for a formal waiting room, establishing a structured, consistent process for drop off and pick up is very important. Transitions can be difficult for young children, especially when beginning a new routine. Clear structure and support for both the child and caregiver can make all the difference in creating smooth transitions into and out of the therapy site which will ultimately strengthens trust and confidence in the process.

The usability of the space is critical and the child-centered play therapist should maintain a strategic and practical stance when considering how to best use whatever space is available to them. As a professional sets up a play therapy space, the clinician's self-reflection throughout that process will set the groundwork for success. Therapists are humans with human sensitivities and vulnerabilities and therefore should consider consulting with a colleague or supervisor when setting up the child-centered play therapy space to help them identify any 'blind spots' in their process that may impact the manner in which they lay out the space or select the toys for client use. The therapist's self-awareness as items are selected for the room is of utmost importance. Toys that the therapist may have strong feelings about may not ultimately be the best choice related to client needs. It is critical that the therapist be prepared for each and every item in the play space to be touched, tossed, damaged, and worn. No item in the room should be of sentimental value to the therapist or be considered "precious" to the therapist. Walls have been known to become a space for a child's self-expression, making washable wall paint well worth the investment.

Although the aforementioned recommendations represent an excellent goal for clinicians to strive for, it is important for CCPTs to keep in mind that child-centered play therapy can also be integrated with other theories and/or modified somewhat to meet the demands of the client and/or limitations of space. Importantly, CCPT can be implemented in all variations of spaces when careful thought and preparation is given to the setup of the office/playroom. The therapeutic relationship and alliance can be built, the child-centered approach can be used, and children manage within the space allotted.

Selecting Toys

In the office/playroom, the therapist should provide toys that will interest children and elicit emotional and creative responses. Toys should be sturdy and safe. Toys that provide play across the developmental stages is also important. Children may want a "re-do" on mastering tasks from a younger stage or have the opportunity to play with a toy that was somehow "off limits" to them. (Landreth, 2012).

The University of Texas' Play Therapy Center recommends the following criteria for selecting toys. "Toys should:

- Allow for exploration of real-life experiences including cultural values, traditions and roles
- Facilitate contact with the child by gaining the child's interest and attention
- Permit reality testing/limit setting

- Provide the opportunity for development of self-control
- Facilitate exploration of the self and others
- Allow children to express their needs symbolically (without any need for verbalization)
- Provide for expression of a wide range of feelings
- Provide opportunities for insight/self-understanding
- Allow for creative expression
- Toys should also be durable, simple, and easy to operate, allow for success & are fun."

The University of North Texas also recommends the following categories of toys:

- "Real-life" and Nurturing
  Doll family, doll house, baby bottle, variety of puppets, animal families, cars, money, cash, register, kitchen food, medical kit, phone, etc.
- Acting-out, Aggressive, Scary Toys
  Bop bag, toy soldiers, guns (colored plastic-not real looking!), scary/aggressive puppets and animals (alligator, shark, etc.), rubber knife, foam sword, handcuffs, etc.
- Creative expression and emotional release:
  Sand, water, paints, craft materials, clay, musical instruments, magic wand, dress-up clothes, etc." (Center for Play Therapy, n.d.)

Explaining the Play Therapy Process

Taking the time to explain CCPT to parents and children is the starting point for the therapeutic process. Play therapy often requires explanation to the parents in order to clarify the process and to dismiss any preconceived expectations. Having parents understand the CCPT process will establish clear boundaries and expectations.

The manner in which a clinician discusses the play therapy process with caregivers should be shaped around the understanding the parent or guardian has about mental health support in general and their perceptions about play therapy. To gauge this baseline, it is best to begin the conversation with an open-ended question such as, "So, [parent] tell me a little bit about your thoughts related to your child receiving support through play therapy." This type of question coupled with related follow-up questions will typically elicit helpful information such as a) how familiar the parent is with mental health interventions/ therapy, b) any preconceived ideas/ biases about the therapeutic process, and c) concerns or question the parent or guardian may have about play therapy.

Once the clinician has grasped the point at which the client and his or her caregivers are entering the therapeutic process, the therapist can then begin to explain a bit about the philosophy of child-centered play therapy and what the child and their family can expect through the process. It is greatly important that all involved understand that CCPT is different from traditional talk therapy models in that the child (client) expresses him or herself through play as this is the 'native language' of children and that, thereby, the therapist will enter into the child's world in order to meet them where they are in their therapeutic process.

Clinicians should let parents know that CCPT is a relatively slow process as compared with some other talk therapy models but can be much more successful and meaningful for young clients. The CCPT approach often unfolds at a gentler pace than traditional therapeutic approaches because communication occurs through the play process rather than through verbal communication. Play is the therapeutic modality. This exploration occurs organically and it not necessarily at the child's current level of awareness. With this in mind, the child-centered play therapist does not interrupt the natural flow of a child's play to ask questions or to engage them in a cognitive process as the child may find this interruption frustrating as it distracts from their most important work (i.e., play) (Kottman, 2011).

Parents/guardians are invested in their child's therapy and growth. Hence, they often seek immediate and frequent communication and updates about "what is going on" with their child. Child-centered play therapists are thereby intentional and supportive as they establish boundaries around communication with the parents. In most states, the parent or guardian of the child holds the right to confidentiality when the child is receiving mental health services. Because parents have the right to know what their child communicates throughout their play therapy session, it is important for clinicians to communicate the significance of child-counselor confidentiality and the clinical process inherent in play therapy. In other words, although a therapist must disclose information to parents or guardians upon request, caregivers will likely have less urgency to know the details of the play therapy session if they understand the overall nature of the play therapy process and are assured that the therapist will communicate with the parent/guardian should anything that is a cause for alarm (i.e., that the child's or someone else's safety is a cause for concern) arise during the play therapy process. It is important for play therapists to understand that cultural groups vary related to how they perceive a child having clinical privacy. Depending on a family's norms and customs the counselor and parents/ guardians should articulate a mutually agreed upon manner and regularity upon which to communicate about the child's presentation and progress.

In CCPT, maintaining the foundations of the therapeutic alliance (e.g. unconditional positive regard, freedom to express difficult feelings) is challenged if the child does not feel that they have privacy in what they express. Providing parents with clear information in the informed consent process will communicate respect for the parent/guardian's rights while requesting their approval to maintain the child's privacy. Informed consent will provide parents with the assurance that they will receive updates on the progress of the therapy and would immediately be contacted if there was any concern for the health and safety of their child (Cochran, Nordling & Cochran, 2010), however, the therapist should also maintain a culturally sensitive posture to ensure that parents are not left feeling anxious about their child's growth and progress. For instance, if a parent feels strongly that they need some level of detail regarding the play therapy session and/ or meetings with the therapist that are scheduled more regularly than normal, the therapist should work to negotiate the child's care so that it is both culturally sensitive as well as clinically appropriate. These challenges are often successfully addressed through parent education and rapport building through conversation at the onset of the therapeutic process.

As the explanation of CCPT is provided to parents/guardians, it is important to be cognizant of and value the parental relationship and investment in their child's therapy. Post (2014) highlights the importance and benefits of consultation with parents prior to and during CCPT. Post (2014) recommends the following "practical guidelines in describing CCPT to parents learning about the child and developing a trusting relationship with parents:

- Addressing objectives and goals
- Relating established goals to the child-centered approach in the playroom
- Providing ongoing parent consultations

Every four or five sessions therapists should meet with the parents without the child being present. The purpose of the ongoing consultations is to maintain and foster a strong therapist-parent alliance, allow the parents and play therapist to collaboratively assess the progress toward goals, and further educate parents about child development, parenting skills and community resources" (Post, 2014).

Children should be informed of what play therapy is, of the limits of confidentiality in therapy, and what steps would be taken if the therapist were concerned about health and safety concerns impacting the child and/or others. The therapist should also explain the method and level of communication that will occur with their parents/guardians. Discussion

with the child about how, when and what will be discussed with their parents/guardians provides an opportunity to develop trust in the relationship. One approach to communication with parents is to inform the child in real time of when you will be speaking with their parents and what you plan to say. At that point, the child can provide input on their level of comfort with what is being shared. An open dialogue can then take place between the child and the therapist on how best to communicate mutually agreed upon information. Circling back to the child about the communication with the parents/guardians further establishes a process of transparency and trust.

This process can be particularly sensitive with a child who is part of a traditional, hierarchical family in which the parent is seen as authoritarian. In these cases, it can be challenging for a child to trust the therapist to do what they say they will do (i.e., maintain confidentiality, support the child, etc.). In circumstances such as these when the clinician senses anxiety or dis-ease from a child when broaching the topic of dialog with a parent/guardian, it is exceptionally important for the therapist to slow down the process and seek to understand how a child is feeling. In these instances it may be important for the therapist and the child to have a conversation about trust, trusting new people, and taking risks with trust. If the counselor has successfully developed genuine rapport with the child, these circumstances offer a fantastic opportunity for the client to grow by finding a working alliance with the counselor as new information is safely disclosed to caregivers and the child learns to take measured relational risk.

Play Therapy: The Process

The initial play therapy session centers around the child getting to know the play area and becoming comfortable with the setting. While the child becomes familiar with their surrounding and the toys, the therapist will begin to establish rapport with the child. Each child will respond according to who they are, and the therapist will respond with unconditional positive regard and empathy. The therapist, following Axline's eight guidelines, establishes an acceptive, caring environment that is a safe, judgement free environment for the child to explore their emotions. The therapist's posture is non-directive and confident that the child will be able to solve problems and challenges that arise as they progress through the therapeutic process. Children typically take a few sessions to acclimate to the play therapy setting as the therapeutic relationship develops. During this time children have been working through some of the easier topics to discuss. This beginning period is known as the *Warm Up* Stage of CCPT. (Cochran, Nordling & Cochran, 2010; Nordling & Guerney, 1999)

Once unconditional positive regard and empathy have been communicated to the child and the therapeutic relationship established, the child moves into the *Aggressive* stage. At this stage, children tend to work on the underlying issues that are central to their behaviors and concerns in school or at home. The child may be working on emotions, situations, behaviors that are very challenging for them. At this phase, some children may regress, some move through this stage without upset, and others may become angry, frustrated, sad, etc. This stage may last multiple sessions and the level of aggression, anger, sadness, etc. can be very intense. An essential aspect of this phase is the reaction/response of the therapist to the child's emoting. The role of the therapist is to remain accepting and empathic while the child is displaying emotions which may include anger, aggression and resentment. This may be challenging for the therapist, however, maintaining and communicating to the child unconditional positive regard is essential to the child to feel secure in expressing their base emotions. (Cochran, et al., 2010)

Stage three is called the *Regression* Stage. The content of this stage may vary, but the core issues that children work on are nurturance, attachment, identity, and relationships. (Cochran, et al., 2010; Nordling & Guerney, 1999). During this stage, the child may engage in age regressed behaviors, such crawling, word pronunciation from an earlier age, etc. The final *Mastery Stage* of PPCT is when the positive changes are integrated into the child's personality. The child is now able to demonstrate self-control, express their emotions appropriately, and has a sense of competency.

CCPT: Considerations for the Current Global Landscape

Currently, the world-wide community is in the middle of the Corona Virus pandemic (COVID-19) challenge. This global reality offers us pause to consider the impact of this pandemic on children. Although current research has not yet caught up to quantifiably measuring the impact of the pandemic on the mental health and well-being of young people, a recent article in Time Magazine suggests that what data does exist is concerning; citing studies indicating that after approximately one month of quarantine about 20% of Chinese children experience anxiety with similar results for depression (Kluger, 2020). The same article warns about the possible long-term effects of a shaken global economy due to COVID-19 will have on today's youth.

Whether internationally or domestically, many children's lives and security have been shaken by the COVID-19 pandemic and it is a critical time for child-centered play therapists to take several considerations into

account as it relates to their work. First, to take note of how their current client's lives have been affected. For instance, many children who typically had the support of caring adults in school settings are now struggling to engage with web-based learning modalities whereas other children have been home-bound with abusive care takers. Additionally, some therapists may find themselves in situations where they are prohibited from providing services in their typical model (i.e., mobile therapy or at a particular agency). Additionally, most therapists must wear a mask to provide services due to COVID-19 related regulations, challenging their ability to connect with young clients. In all cases, child-centered play therapists must remain focused on how they can best serve children by using the means of their play as an ever-important point of communication.

As the current global and domestic sociopolitical and health climates challenge the work of child-centered play therapists, play therapists may wish to rely on the following tips in order to leverage their clinical skills to help individual clients and the collective heal and recover:

- Remain committed to the value of play therapy and its impact on children.
- Maintain a flexible clinical posture when considering alterations in space or toys available, sanitation schedules, physical proximity to clients, and/or session schedules.
- Consider using mobile play therapy kits to create 'pop up' play therapy rooms wherever you are able to meet with clients (i.e., schools, churches, client homes, hospitals, etc.).
- Partner with parents to allow for 'live time' video-based play therapy sessions wherein the clinician is able to provide therapy virtually with the parent present to ensure safety.
- Check in with clients regularly and consider virtual methods of contact (i.e., phone, video conferencing if/when physical meetings are not possible.
- When time between sessions is longer than usual, consider remote parent consultations as a way to support young clients and their families.
- Create mini play therapy kits for families to use in the safety of their own homes that include one or two small toys from each of the toy categories.
- Consider using filial therapy tenets to help parents apply the basic tenets of play therapy with their children.

- Use video conferencing as a means to offer caregivers feedback related to their implementation of filial therapy tenets with their child.
- Encourage parents to record themselves providing filial therapy for their child and offer feedback and support through phone or video conferencing.
- Remember that even if it is not implemented in its most efficacious form, play therapy will bears therapeutic value to the client, even if just by the therapist being fully present with the child for a period of time.

Conclusion

While child-centered play therapy efforts may be challenged by economic or circumstantial hardships, it is the responsibility and burden of the child-centered play therapist to identify ways to continue to support the growth and development of children by using their play as the most valued form of their self-expression. While this process ideally occurs in a carefully appointed play therapy room with a specifically curated toy selection, the universal Rogerian therapeutic factors (i.e., congruence, unconditional positive regard, and empathy) can be applied anywhere, anytime, with anybody! The child-centered play therapists maintains this posture, knowing that they will positively impact children by genuinely prizing them throughout their play process.

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Child-Centered Play Therapy, Learning From The Child Through Empathic Listening

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Play is a natural avenue for a child's self-expression and authentic emersion in their own self-guided world. Child-centered play therapy allows the child to play through their feelings in an environment that is supported with conditions set forth by Rogers (1957): congruence, unconditional positive regard and empathy. (Axline, 1969; Landreth, 2012). Children see the world with their hearts, while adults try to "fix" problems with their minds. As a CCPT, Landreth (2012) encourages therapists to relate to a child "heart to heart" and realize that what we know, as adults, is unimportant in the playroom. Be still within yourself and follow the lead of the child.

I am currently a graduate student at Kutztown University of Pennsylvania completing my masters in Marriage and Family Therapy. The following sessions were "practice" sessions toward my work as a child-centered play therapist and were my first sessions using a traveling play room and traveling sand tray. The first session was provided in 30 minutes and was my first session with this child. To protect his identity, we refer to the child as B throughout the session. I will also refer to myself as therapist or T throughout this session. The second session was provided in 30 minutes and was my first session with a 10-year-old girl who will be referred to as C throughout the session and I will be referred to as T or therapist.

The materials chosen for the sand tray session with B reflect a variety of non-specific toys, most of them wooden, specifically chosen because they are non-descript. They are a variety of miniatures such as people, animals, large and small wooden blocks, different wooden shapes, and vehicles as well as items to scoop, cut and hold the sand. They also represent a variety of ethnicities, races and genders as well as non-specific wooden "humans" that can be assigned whatever ethnicities, race or gender the child wants. I felt it was important to be conscious of picking items that did not already have a "background story" or were specific "characters" for the child. Using non-descript pieces allows the child to play freely and create the stories within their play. I wanted to make sure the "humans" could represent a variety of different people in the child's life and that they

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could identify with some of the miniatures in some way. I chose a wide variety of animals, including ones that might be deemed "angry or scary." More specifically, I added fierce looking creatures so the child could possibly identify with that specific creature's emotion or perhaps use it to depict someone in his or her life. I added blocks and other non-descript wooden shapes, so the child could use those pieces to "become" anything they can imagine such as a house, park, school or other building structure. (Axline, 1969; Landreth, 2012)

Sand Tray Child-Centered Play Therapy

The client, B, age 8, is considered by his parents to "be well behaved in school as well as a good student, naturally athletic, witty, inquisitive and personality driven. He also can have a bit of a temper and hates to lose." We started our session with an introduction about the "rules" of our space. (Cochran et al, 2010)

> T- Hi and welcome to the playroom. My name is Ms. Christine and I am so happy you are here to play in this special room with all of these toys. In this room you can do *almost* anything. I will let you know if there is something that you can't do, okay?
>
> B- Okay.
>
> T- I'll let you know when we only have 5 more minutes to play and then again when we only have 1-minute left to play.
>
> B- Okay! (Laughing)

B dives into the sand. He gets sand outside of the sand box, doesn't notice. He starts piling toys into it, burying blocks and working on building something. He spills more sand out.

> B-oops…sorry!
>
> T- I told you that I would let you know if there was anything you can't do.
> B- Oh so I can put sand everywhere? (Eyes were very wide and excited)
> T- you are wondering if you can put sand everywhere!
>
> B- Can I?
>
> T- you are really curious about putting sand everywhere.

B looks at me and then looks at the sand then looks at me again. He is thinking about all of this. He dives back in again to the sand with miniatures.

He "decides" to not purposely put sand everywhere but also isn't being too worried about the sand flying out of the traveling sand box. He starts to build what looks like a bridge.

> B-I have to make this bridge very secure because if it isn't secure the cars can't get over it and get to work.
>
> T-you are making that bridge very secure.
>
> B- Want to help me?
>
> T- you are wondering if I want to help
>
> B- Yeah take these sticks and put them here….no not there right here and then move the sand this way so it is secure. Okay? I will build this part so the police car can start going over.
>
> T-You really have plans on how you want this built.
>
> B- yes follow my directions and we can't go wrong with the mission!
>
> T- You want to make sure I follow your directions
>
> B- yes – you are doing well…keep putting sand there.

B continues to play with a lot of energy and verve- he finishes his bridge and grabs what he is calling the police car (it's a wooden car).

> B-this is the police car, but it's a good one. Not like the bad ones that do bad things to people they don't like.

This play therapy session occurred approximately one week after the murder of George Floyd.

> T- You want me to know this is a good cop, not a bad one.
>
> B- yeah grandma was talking about the bad ones with papa and was sad about a man who died because a policeman made him die.
>
> T- so you heard your grandma and papa talking about a man who died because of a police officer.

He began a long talk without taking a breath.

> B- Yup- Papa said that police people are good and that I shouldn't be afraid of them but sometimes there are mean ones. So I told him that maybe it's like when my mommy said she didn't like my doctor and she wanted to find a new one. Not everyone is going to like everyone or be good. I feel bad for my best friend- he is my very

> very very best friend and dark skinned and I don't want the police to be mad at him and get him. (While he talks he is using the alligator toy to attack the police officer and car) So I am going to make a plan that if they try to get him I am going to tell them get me too and then call my mommy because my mommy said we have to protect our brothers and sisters and my best friend is my brother and so I will have them call my mommy or daddy and they will tell the bad police not to get my friend. Or I'll have them call papa- I know both my parent's cell phone numbers (he recites them) and that's what the plan will be. Is that a good plan?
>
> T- You are wondering if that is a good plan for you and your best friend.
>
> B- I know it's a good plan- I have very good plans- okay you take this police car and have it go help that tree that fell…that will be a helpful police woman. Be helpful and good okay?

I start my role as helpful police person.

> T- hello tree I am a police person and I am here to help! Can I help you stand up?
>
> B-Yes thank you I need help standing… get more sand policewoman!
>
> T- here is sand to help you stand firm and strong
>
> B- you are a really good policewoman
>
> T-You think I am a really good policewoman
>
> B-Yup

B continued to play in the sand happily and give me direction on how "to be a really good policewoman." He was given a five-minute warning to end his play session and then a one-minute warning to prepare him adequately for the end of our time together.

What was revealed throughout his play was his deep worry about something he had overheard and the amazing ability to process that worry using his play. B articulated what he was feeling and thinking in relation to intense social issues that are current in today's society. At times throughout the therapy I fought my own inclinations to interject or ask questions. However, allowing B to fully immerse and experience his play on his terms

while articulating his feelings throughout effectively allowed him to lead the way.

Child-Centered Play Therapy with a Traveling Toy Room

The materials chosen for the traveling toy room reflect a variety of non-specific toys. They are a variety of miniatures such as people, animals, large and small wooden blocks, different wooden shapes, and vehicles. In addition, a nursing bottle, rubber knife, rolling pin, bendable doll family, small traveling PlayDoh, dart gun, handcuffs, 10 toy soldiers, play dishes and spoons, non-descript, bean bag balls, popsicle sticks, cotton rope, hand puppets, aggressive alligator toy, small bedroom, bathroom and kitchen furniture, band aids, and costume jewelry. All "human" toys represent a variety of ethnicities, races and genders as well as non-specific wooden "humans" that can be assigned whatever ethnicities, race or gender the child wants. It is important to be conscious of picking items that did not already have a "background story" or were specific "characters" for the child. Using non-descript pieces allows the child to play freely and create the stories within their play. I wanted to make sure the "humans" could represent a variety of different people in the child's life and that they could identify with some of the miniatures in some way. I chose a wide variety of animals, including ones that might be deemed "angry or scary." I added fierce looking creatures so the child could possibly identify with that specific creature's emotion or perhaps use it to depict someone or something in his or her life. I added blocks and other non-descript wooden shapes, so the child could use those pieces to "become" anything they can imagine such as a house, park, school or other building structure. (Axline, 1969; Landreth, 2012)

The client, C is age 10 and considered by her parents to "be very conscientious with everything she does. She strives for perfection and she is extremely competent. She is her own worst critic and has presented forms of anxiety which cause tension in the home." We started our session with an introduction about the "rules" of our space (Cochran et al, 2010). Our session lasted 30 minutes.

> T- Hi and welcome to the playroom. My name is Ms. Christine and I am so happy you are here to play in this special room with all of these toys. In this room you can do *almost* anything. I will let you know if there is something that you can't do, okay?
>
> C- Okay (shyly)
>
> T- I'll let you know when we only have 5 more minutes to play and then again when we only have 1-minute left to play.

Child begins to take out all the Popsicle sticks and lay them in very neat frames. She begins to construct what looks like the frame of a house and is very systematic about it. Child is giggling as she builds, perhaps slightly anxious of the unknown? She then quickly draws her attention to the toys. She gets a very serious look on her face and begins her "work." She seems very systematic about what she is choosing and where she places it.

T- You have a very specific plan about where you want everything.

C- uh hmmm...

T- You made a straight line with that.

C takes many wooden blocks and carefully looks each one over. She chooses to get rid of some. She puts those blocks back exactly where they came from in a precise way.

T- You don't want those anymore.

C- No they didn't work in my mind the way I wanted them to.

T- you thought they were going to do something else other than what they did.

C- Yes, they didn't make it look like I wanted.

T- You wanted it to look a certain way and they didn't look like that.

C-uhh--hmmmm

C continues play making very straight lines with the blocks and sticks.

T- Those are very straight lines

C- Bedroom. (she points) Bathroom (she points)

T- There is the bedroom. There is the bathroom. You know exactly where you want to put these pieces.

C- I do (giggling)

C gets serious again in her "work." She works in silence and is very focused.

T-You are making sure it is very straight

C- I like things neat

T-You like things to be neat

C seems to be questioning where to put her remaining pieces of the house frame.

T- You are not sure how you want to lay that

C- Hmmmm

Child happily put the piece where she wants after trying many different scenarios.

T-You are happy about how you laid that now

C- uh, hmm this is a toilet bowl (laughing)

T-You think it's very funny that that is a toilet bowl

C- Its very funny the toilet bowl (Laughing)

T- you find that very funny

Child gets right back to work.

T-You are getting everything just the way you like it

T-You are fixing the scarf around the house, you are very satisfied with how neat it looks.

C-I like things straight and neat

T- Making things straight and neat makes you satisfied and happy.

C- I feel calm when things are neat

T- You like things neat and it makes you calm when they are.

C- I hate a mess! (Laughing as she continuously makes everything just so…)

T- You don't like mess

C- Is that okay?

T- you are curious to know if I think it's okay to like things neat

C- Do you like things neat?

T- You want to know if I like things the way you like things

Child picks up a doll and hands it to me and says,

C- You are the mommy

T- Okay I am the mommy

She directs me to play out a scenario where I am the mommy and she is the child and she is cleaning up after making cookies. I fully take on the role I was assigned and she acts out a "scene" where the child cannot get the cookies right but eventually does and is cleaning up the kitchen after baking. I was conflicted here whether or not I was supposed to make it known, through my role as mommy, that I think its fine to like things neat but show that it doesn't matter to sometimes be messy. I decided to let the child lead during this role-play. She asked if I liked the cookies and I commented the cookies were delicious and how grateful I was for C making them.

The theme I keep seeing here is this need for perfection; to be "good" and "neat." I believe this is all linked to self-esteem; C is turning 11 and developing physically and emotionally. Her explorations are valid as she embarks into pushing away from her parents and grounding her own thoughts and feelings. However, these thoughts and feelings cause anxiety within her- an internal struggle to be perfect. Even within the therapy, you can see she puts tremendous pressure on herself to succeed and do things "right."

C- Okay now the mom goes to work and the dad is on the toilet

A tremendous amount of laughter and giggling- she seems to really enjoy making me laugh as well.

T- (Laughing) The dad is on the toilet- you think it's very funny that the dad is on the toilet

C-Yes, the dad is staying in there a really long time!

Again, C is laughing as am I.

T- the dad being on the toilet is very funny

C-Laughing….

She goes back to her play continuing to construct a house and barn, parking garage, and backyard. She notices a piece of furniture she had carefully placed keeps falling over. She corrects it several times.

T- The piece of furniture keeps falling and you are very frustrated it won't stay in its place.

C- I am very frustrated- why won't it stand up?

T-You are wondering why it won't stand up!

C- I'm asking you why it won't stand up! (laughing)

T-You are asking me and getting very frustrated about why this piece of furniture won't stand up.

C- (Lots of laughing)- you won't answer me!

T- You are frustrated that I don't have an answer

C- argghhh (laughing)

She eventually gets it to stand up with the aid of another piece.

Our session lasted for 30 minutes; I gave her a five-minute warning and then a one-minute warning to alert her time was over. At the five-minute warning I could have predicted she would begin to clean up, which she did. She very neatly began to put everything away exactly where it came from. She was very deeply involved in her play, creating scenery, characters and spaces that reflect her life. For adults, it is generally easy to talk about how they feel or what they want, or how what they want makes them feel! I suspect that for children, working that out in the playroom would alleviate any anxiety that might come with the need to "do everything right." Eventually, this particular child could begin to see, through play therapy, that situations can change, be messy, and still be okay. Play therapy can be the catalyst to show that in a world of rigid straight lines there might be beauty in the twists, turns and curves of all that life has to offer.

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What Did Carl Rogers Say on the Topic of Therapist Self-Disclosure? A Comprehensive Review of His Recorded Clinical Work

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Abstract. *Self-disclosure is the very substance of psychotherapy. Therapist self-disclosure, on the other hand, has long been an area of contention and debate among practitioners, theorists, and researchers. Though staunch edicts against therapist self-disclosure are increasingly rare these days, the various theoretical orientations still weigh heavily on how disclosures by therapists fit into the clinical rationale. It is somewhat widely held that humanistic theorists, including Carl Rogers, were proponents of therapist self-disclosure in the interest of being genuine and open. This study covers all of the known recorded work of Rogers, and takes a qualitative look at instances in which Rogers made self-revealing statements to clients. Results indicated that Rogers almost never made self-disclosing statements to the clients with whom he worked, far less than would be expected based on the broader literature on the frequency of therapist self-disclosure. The implications for the theory and practice of person-centered therapy as well as humanistic/person-centered therapy are discussed.*

Historically the role of therapist self-disclosure in session depended largely upon the therapist's theoretical orientation. For instance, in psychoanalytic schools of thought, self-disclosure is viewed as a mistake of the novice therapist who is attempting to help clients overcome their resistance (Auvil & Weiskopf-Silver, 1984; Freud, 1910/1959). Freud considered these revelations to be inappropriate and claimed that they were in contradiction to his insistence that a therapist act as an impenetrable mirror to clients, reflecting only what is shown to him or her by the client. Of course, over time psychodynamic literature became more relaxed on the topic and thoughtful sharing of personal thoughts, emotions, or experiences is believed to add authenticity to interpretation, making therapy feel more real for clients (Jacobs, 1997). Going further Levinson (2010) has built a

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modern dynamic theory around freely sharing therapist reactions with clients as they are emerging in the therapy relationship.

At the other extreme from Freud's position against therapist self-disclosure, humanists embraced a more liberal stance toward therapist self-disclosure. The humanistic movement has heralded the charge for spontaneous human relating through mutual self-disclosure in therapy (Curtis, 1981; Jourard, 1971). When adopting a humanistic perspective, therapist self-disclosure is thought to be a fundamental tenet of being congruent and genuine in the therapeutic relationship (Nilsson, Strassberg, & Bannon, 1979).

The liberal stance of the humanists toward therapist self-disclosure is rivaled only by feminist theory, which holds that therapist self-disclosure is important in narrowing the power differential between client and therapist (Mahalik, Van Ormer, & Simi, 2000). Similarly, Hill and Knox (2002) promote the use of self-disclosure in therapy as a way for different cultural experiences to be acknowledged and respected. Given that some client populations are underserved by mental health professionals, therapists are called upon to not only recognize cultural factors that may be salient to providing services to clients, but should make every effort to effectively deal with their own cultural biases (Sue, 2015; Sue, Arredondo, & McDavis, 1992). One way in which a therapist may decide to address his or her own limitations with respect to cross cultural understanding is to openly acknowledge these to the client, thus making understanding/misunderstanding a topic to be explored in therapy (Sue, Ivey, & Pederson, 1996). Barnett (2011) goes as far as to write that rigid avoidance of therapist self-disclosure in a multicultural context was inappropriate. Cognitive behavioral theory does not offer direct guidance with respect to therapist self-disclosure, but respects therapist disclosure as a tool for change and relating to clients (Miller & McNaught, 2016).

The research on therapist self-disclosure adds further depth to the topic: Therapists and clients seem to agree that the timing, nature, and extent of the self-disclosure should be based on the quality of the client/therapist relationship in terms of the therapeutic alliance (Maroda, 1994; Weiner, 1983; Wells, 1994). In a qualitative study of Levitt and colleagues (2016) looked at 52 therapeutic dyads at college counseling centers. Of these 52 dyads, 46 had some level of therapist self-disclosure associated with the work. Disclosures were rated as largely favorable and perceived as humanizing the therapist. Interestingly, the frequency of therapist self-disclosure was unrelated to outcome as measured by symptom reduction. In a robust qualitative metanalysis of 21 studies, the benefits as well as the risks of therapist self-disclosure were explored (Hill, Knox, & Pinto-

Coelho, 2018). These authors parsed out immediacy statements from other types of therapist self-disclosures and found that immediacy statements were more helpful in facilitating clients exploring issues openly, whereas other forms of therapist self-disclosure were more helpful in providing support and enhancing the therapeutic relationship. In general, therapist self-disclosure and immediacy statements had a positive impact on the therapy process, but it is worth noting that in 30% of the cases disclosures were viewed negatively.

Other qualitative work has found similar patterns with therapist self-disclosure; both being facilitative as well as hindering the therapy relationship (Audet & Everall, 2010). Self-disclosure by the therapist was associated with closeness in the therapy relationship and described as encouraging, egalitarian, and comforting. These authors note that there is a risk to therapist self-disclosure and included role confusion/reversal between the therapist and the client, clients feeling misunderstood and overwhelmed.

Hill and Knox (2002) described therapist self-disclosure as a rare but potentially potent intervention. They described it as the Goldilocks principle: too often or too infrequent and the impact is lost. When the working alliance is strong, therapists tend to disclose more than when the alliance is weak (Pinto-Coelho, Hill, and Kivlinham, 2016). In analogue research, when the working alliance was strong, therapist disclosures led to the therapist being viewed as more expert and the session having more depth than when the alliance was weak. Therapists tend to disclose more often and report greater comfort doing so later rather than earlier in their careers (Hill, Knox, Pinto-Coelho, 2018). Nevertheless, the majority of therapists report disclosing at some point in therapy, with Henretty and Levitt (2010) reporting that 90% of therapists report disclosing occasionally and Carew (2009) sharing that 19 out of 20 practicing therapists acknowledged disclosing something to their clients. Still, therapist self-disclosure is infrequent when all therapist response modes are considered, with disclosure occurring in 0-5% of cases (Hill, Knox, & Pinto-Coelho, 2018). This is in line with earlier research by Hill and her colleagues (1988) which examined over 16,000 therapist responses with about one percent representing a disclosure by the therapist. In essence, most therapists self-disclose, but disclosures represent a very small portion of overall responses.

Given Carl Rogers' seminal work (Rogers, 1951) in humanistic theory, he is often referenced as being a proponent of therapist self-disclosure (Audet & Everall, 2010; Carew, 2009; Farber, 2006). However, there is no evidence of this in Rogers' writings. It is indeed true that humanists believed that therapist expressing feelings and reactions to clients

in an open fashion, without maintaining a façade is critical (Carew, 2009; Curtis, 1981; Jourard, 1971), but it would seem that Rogers never wrote explicitly about therapist self-disclosure. Despite this, we can make some inference about Rogers' stance on therapist self-disclosure by his reluctance to directly answer most questions that were asked by clients (Kegan,1994, as cited in Frankel & Johnson, 2015). In fact, these contemporary Person-centered theorists along with others (Brodley, 2011) warn that therapist self-disclosure can create a power imbalance between therapist and client in which the therapist assumes control of the session, thus interfering with the client's exploration of their own narrative. This brings us to the purpose of the present study: What did Rogers actually say in therapy. Specifically, did he disclose to his clients?

Method

Lietaer and Brodley (2003) published a manuscript outlining a comprehensive listing of the therapeutic work of Carl Rogers. Subsequently, these authors took on the daunting task of obtaining video and audio recordings as well as existing transcripts of sessions and compiling an archive. This work is comprised of 172 therapeutic sessions conducted by Carl Rogers and represents a comprehensive body of Rogers' known recorded work (Lietaer & Brodley, 2006).

These transcripts were reviewed in their totality, consisting of 8,668 responses by Rogers (see Appendix A for more detail). All self-disclosing statements were identified. These statements were then categorized by the primary researcher and two other licensed psychologists. The mean years of practice among these psychologists was 20.3 years. All three are well versed in process research and are published in this area. For the purposes of this study, both the definition for therapist self-disclosure as well as the categories for therapist self-disclosure were adapted from the work done by Hill and Knox (2002) and Knox and Hill (2003) respectively: Therapist self-disclosure was defined as verbal statements that reveal something personal about the therapist (Hill and Knox, 2002). These disclosures could either be spontaneous or in response to an inquiry by a client. The categories of therapist disclosure included the following: Disclosures of facts, feelings, insights, strategy, reassurance/support, challenge, and immediacy. Please refer to Knox and Hill (2003) for more detail. When possible, consensus among the therapists was reached regarding which category of self-disclosure each respective interaction belonged. When no consensus could be reached, the majority indicated in which category a response was coded.

Results

Upon review of Rogers' work, it became evident that he did not disclose much to his clients. Out of 8,668 responses, only 21 could be considered self-disclosing. That is one disclosure every 413 responses or 0.24% of overall responses. Please refer to Appendix A for a listing of sessions in which disclosing statements were made. After reviewing the disclosing statements, they were categorized by the rubric outlined by Knox and Hill (2003): 12 responses were considered disclosures of immediacy; 9 were disclosures of fact; 7 were disclosures of reassurance/ support; three were rated as disclosures of feeling; and finally two statements were rated as disclosures of challenge. Appendix B is a graphic depiction of these findings.

Examples of each of the disclosure types may help illuminate the intersection between contemporary understanding of therapist self-disclosure (Knox and Hill, 2003) and Rogers' actual therapeutic work. The most frequent type of disclosure was that of immediacy. When working with Mike, during the first session, Rogers commented, "Uh, I guess I feel very appreciative really that you've been willing to share this much with me" (Brodley & Lietaer, 2006, Vol. 10, pg. 40). The second most common type of disclosure Rogers made was that of fact. One such disclosure was made to Mrs. Oak during session 18 when he said, "I seem to have a terrible cold today." (Brodley & Lietaer, 2006, Vol. 8, pg. 134). Rogers offered a disclosure of reassurance/support to Herbert Bryan during the third session (Brodley & Lietaer, 2006, Vol. 2, pg. 57): "I think you are definitely making progress, and the kind of thing that has more significance to me than some of the intellectual things that you do in the realm of-feeling and action." One of the disclosures of feelings that Rogers made (Brodley & Lietaer, 2006, Vol. 2, pg. 94) was also to Herbert Bryan during the 5th session: "Yes, I'm inclined to be skeptical too that you can find the answer in a pigeonhole." Finally, the least common type of self-disclosure made by Rogers was that of challenge. In his work with Mrs. Int in the 5th session, Rogers commented, "But I think that you and I want something very different for you" (Brodley & Lietaer, 2006, Vol. 5, pg. 35).

Discussion

Carl Rogers was one of the first therapists to widely embrace the novel technology at the time which allowed for recording of conversations, or therapy, as it occurs. Rogers saw the tremendous value that audio, and later video recording, had when it came to understanding the therapeutic process (Rogers, 1980). What could this new technology reveal? A fundamental question that is still being answered, with all the imbued complexity and richness.

Nevertheless, the work of Brodley and Lietaer, (2006) gives a depth to the literature that cannot be overstated. We now know, not only what Rogers wrote in regard to therapy and the process of human development, but we get a substantial look (not a glimpse) into how Rogerian theory actually plays out in therapy. The present research explores a relatively circumscribed aspect of the therapeutic process: therapist self-disclosure. In a nutshell, Rogers did not disclose much. In fact, only 0.24% of his responses were self-disclosures. This is about a quarter of what is found in the field of psychotherapy as a whole, where about 1% of therapist responses are self-disclosures; still a relatively rare phenomenon. There are a couple broad assumptions that can be drawn from this simple statistic: First, therapist self-disclosure was not a central part of Rogers' practice. Though the transcripts available undoubtedly represent a minority of Rogers 'clinical work, there is no reason to believe that they were a substantial deviation from his way of being in therapy in general. Secondly, in the absence of specific writing or discussion on therapist self-disclosure, and given that much of the recordings were done expressly to demonstrate the person-centered approach to therapy (Brodley & Lietaer, 2006), it is relatively safe to say that therapist self-disclosure was not a central component of the person-centered approach.

Beyond the more apparent assertions above, there are significant questions and limitations in the current work. Most notably is the dearth of self-disclosures. With disclosure being such an infrequent response, there simply is not enough data to do a qualitative analysis of any substance. That being said, some anecdotal observations about the disclosures Rogers made merit sharing. The primary contraindication to using self-disclosure in therapy is the possibility of a role reversal between the client and therapist, which shifts the focus of treatment away from the client (Curtis, 1981; Matthew, 1988; Wells, 1994; Widmer, 1995). All of Rogers' disclosures were brief in nature and none detracted from the focus on the client. In three instances, disclosures were in response to direct questions from the client, all other disclosures were spontaneous in nature. When a client asked him the question, he simply answered it and returned his attention to the content being discussed previously. Though Rogers clearly did not engage in therapist self-disclosure or openly address it in writing, he certainly was not opposed to sharing of himself, either when asked or when it was germane to the client's dialogue.

Some therapists view the sharing of certain topics to be strictly forbidden. For instance, it is thought that self-disclosure about personal problems, fantasies, and unresolved countertransference is almost always unhelpful to clients (Coyle, 1999, Hill, 1988). Rogers made only one comment that was rooted in a previous personal concern. He shared with

Jim that he could relate to his feelings of being "no damn good to anyone" (Brodley & Lietaer, 2006, Vol.11, pg. 84). This was the most vulnerable disclosure Rogers made, and in post-session commentary he acknowledged that it was out of character for him. Nevertheless, the client, Jim, who was deeply depressed and minimally responsive began to open up following Rogers' disclosure. Given that Rogers phrased his comment in the past tense, we might infer that his issue/countertransference was resolved. So, Rogers use of self-disclosure was across the board judicious, focused on the client, and did not seem to hinder the therapy process.

Conclusion

Therapist self-disclosure does not seem to have a formal place in the person-centered approach. It is neither forbidden nor endorsed by Rogers in his writings. Other humanistic authors more formally addressed and endorse the liberal use of therapist self-disclosure (Jourard 1971). When writing about the expectation held by therapists that clients be completely open and honest during sessions, Jourard (1971), in a seemingly flippant manner, suggested that therapists should be willing to answer any of the questions that they routinely ask clients. I suspect that there was a hint of seriousness to Jourard's statement, since he viewed mutual self-disclosure in any relationship, including a therapeutic dyad, as a fundamental aspect of establishing a healthy relationship.

Rogers managed to form deep therapeutic relationships with clients without sharing much if any specific details about himself—though he certainly shared himself. Both proponents of therapist self-disclosure and critics of therapist self-disclosure would agree that the focus of therapy should always be the client and not the therapist—a task that Rogers accomplished exceedingly well. With this in mind, contemporary person-centered therapists, and in fact I would argue that all therapists, regardless of theoretical orientation, would do well to follow the example set forth by Rogers and ensure that any disclosures they make are in the interest of serving the client. Additionally, fitting broadly within the person-centered approach, therapist disclosure should not be viewed as a technique to be utilized in specific instances. If therapists are open to making disclosures, these should be done in the interest of spontaneous human connection and not be part of a therapeutic script.

Reviewing these transcripts was a remarkable experience for me. My depth and understanding of the person-centered approach and, more specifically, Carl Rogers grew considerably. The door is now wide open for future research. Beyond the present study, a qualitative analysis of other therapist response modes is now possible. A closer look at the work of

Rogers may confirm person-centered theory, extend it, or perhaps revise it. In essence, results of such analysis may further the development of the person-centered approach. The transcripts also readily lend themselves as a resource for training therapists in various disciplines. Finally, as others look at these transcripts, I would encourage a process of curiosity, spontaneity, and creativity. This would be only fitting, as these elements were intricately interwoven into the work that makes up this archive.

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Client	Therapist Responses	Self-Disclosures	Immediacy Disclosures
Herbert Bryan	614	3	2
Frank	54	0	0
Mary Jane Tilden	228	0	0
Ett	711	1	0
Int	434	1	0
Vib	485	1	0
Dem	339	0	0
Sar	290	0	0
Zak	49	0	0
Oak	1780	7	3
Bik	48	1	0
Sup	39	0	0
Mike	119	1	1
Roc	93	0	1
Mun	40	0	0
Lin	143	0	0
Necta	228	0	0
Fas	60	0	0
Loretta	74	0	0
Elaine	154	0	0
Joan	54	1	0
P.S.	75	0	0
Jim	143	3	1
Gloria	71	0	1
Sylvia	114	0	0
Kathy	91	0	0
Dione	222	0	0
Anna	132	0	1
Phillipe	55	0	0
Alphonse	61	0	0
Irene	104	0	1
Julia	126	0	0
Margaret	52	0	0

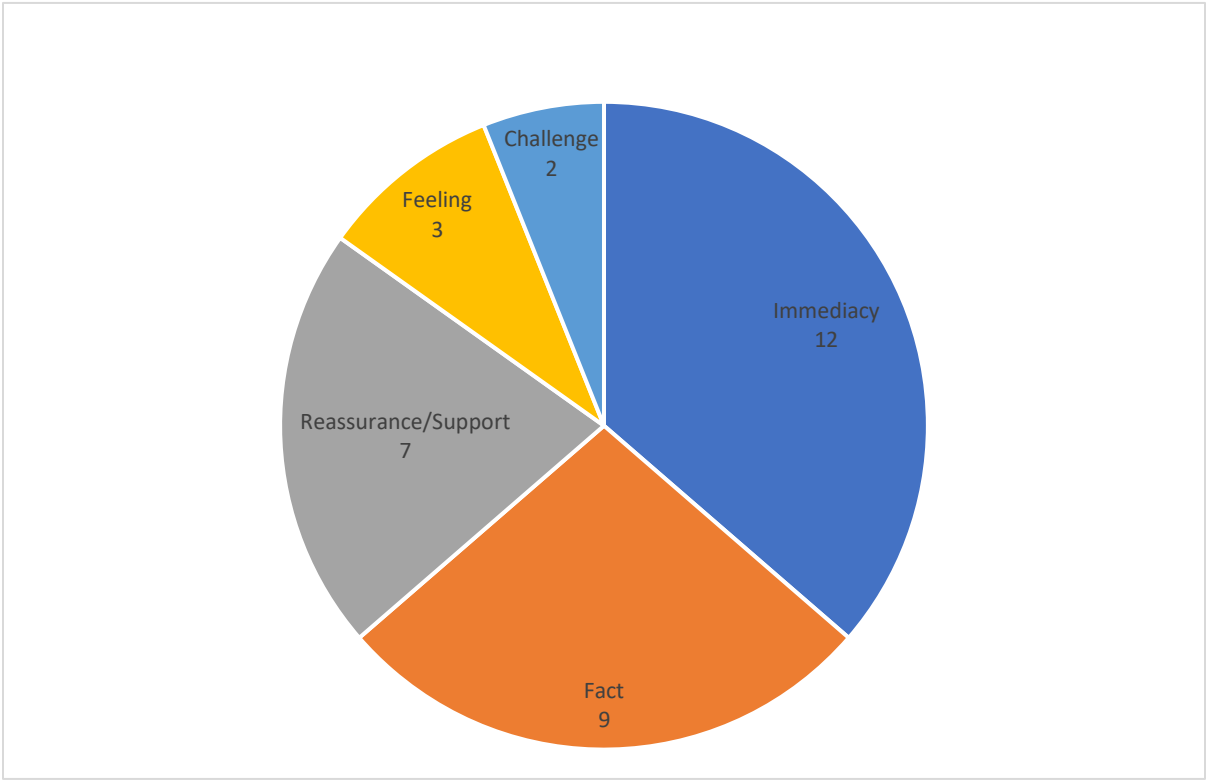
Mark	48	0	0
Jan	72	0	0
Beate	44	0	0
Gina	27	0	0
Reiko	106	0	0
Ms. G	53	0	0
Jill	122	0	0
Richie	64	0	0
Daniel	81	0	0
Ellie	19	0	0
Vivian	57	1	0
David	56	0	0
June	135	0	0
Peterann	67	0	0
Mary	138	0	0
Louise	81	0	0
Steve	58	0	1
Lydia	158	1	0
Total:	8,668	21	12
Percentage of Total Responses		.24%	.14%

Appendix A

Therapist Response Tally

Appendix B

Number and Type of Self-Disclosures Made By Rogers



Physical Therapy Student Attitudes and Understanding Related to the Person-Centered Approach

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Introduction

Physical therapists treat many acute and chronic conditions that create personal, social, psychological and economic burdens. When physical therapy students begin engaging with clients during clinical rotations, the development of a compassionate bond between student and client is crucial (Bohart & Rosenbaum, 1995; Cornelius-White, 2006; Bayliss & Strunk, 2015). A strictly biomedical model cannot fully address the complex clinical nature of pain and disability, nor can it fully address the psychological distress that clients suffer (Fuentes, et al., 2014). A strictly biomedical approach tends to place less value on life factors such as family support, motivation, internal locus of control, personality styles, and daily obstacles that might interfere with the processes leading to rehabilitation (Josephson, Woodward-Kron, Delany & Hiller, 2015). Brodley (2019) described the need for a growth-promoting climate. This point is at the heart of the profession's shift from the Nagi Model of Disablement (biomedical) to the International Classification of Functioning (ICF) (a more biopsychosocial model) paradigm.

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Person-centered approach strategies have been correlated with improved physical therapy outcomes (Josephson, Woodward-Kron, Delany & Hiller, 2015). The person-centered approach was first developed in the 1950's by Carl Rogers (Cohen, 1994; Wilson, Chaloner, Osborn & Gauntlett-Gilbert, 2017). The person-centered approach is characterized as care, acceptance or unconditional positive regard, understanding and genuineness demonstrated by the clinician (Bohart & Rosebaum, 1995). Current physical therapy practice includes three main factors consistent with the definition of the person-centered approach: Shared goal-setting, shared intervention planning, and the bond between client and therapist (Diener, Karbela & Louw, 2016). This involves an attempt to understand the client empathically and relieve psychological suffering (Brodley, 2019).

Appreciating the importance of the person-centered approach in physical therapy practice, this study sought to explore how, and the degree to which, physical therapy students integrate this clinical skill. The American Physical Therapy Association implicitly supports the person-centered approach when one considers that stated values such as respect for persons, integrity in relationships, compassion, and client self-determination are central themes found in The Core Values and Code of Ethics (American Physical Therapy Association, 2017; Babatunde, MacDermid & Macintyre, 2017). These principles are generally accepted as factors that improve treatment outcomes. Therefore, the challenge for educators is to determine whether physical therapy students recognize, integrate, and attempt to implement these principles.

Despite the shift toward person-centered approaches, there are few empirical studies focused on student understanding and skill development of the person-centered approach. Exploring this educational dynamic may provide support for educational programs as they seek to improve curricula. The degree to which physical therapy students understand and develop the person-centered approach needs further inquiry. To date, no study has investigated physical therapy students' understandings and skill development of the person-centered approach.

Literature Review

Physical therapist perceptions of interpersonal relationships and the person-centered approach is an important factor for positive outcomes in physical therapy through unconditional positive regard for the client's experience (Cohen, 1994; Qasem & Canby, 2016). Client interaction is far more than collecting concrete data; it also involves the affective bond between client and therapist. Client-therapist interactions characterized by a flat, neutral or sterile communicative approach reduce the potential for

optimal outcomes (Cohen, 1994; Fuentes, et al., 2014). Diener, Kargela and Louw (2016) found that professional interactions with physical therapists were more highly rated by clients when the client felt heard and understood (Culp & Mannion, 2011; Brodley, 2019).

The benefits of facilitating the person-centered approach in physical therapy practice are appreciated more now than in the past. Older educational tactics of trying to influence the physical therapy client adherence by overly focusing on patho-anatomic explanations proved ineffective (Bohart & Rosenbaum, 1995; Qasem & Canby, 2016). The clinical challenges faced by physical therapists are more effectively met by understanding the client's perspective and life influences. Due to the complicated nature and expansive scope of functional limitations managed by physical therapists, a combined physical and psychological approach has become increasingly more accepted (Bayliss & Strunk, 2015). This has increased the need for physical therapy education programs to teach students the concept of the person-centered approach.

The ability, on the part of the clinician, to positively affect client adherence directly influences client future success and recovery (West & Cox, 2014; Ramklass, 2015). Efforts to develop a person-centered approach has been demonstrated to improve outcomes in multiple professions (Josephson, Woodward-Kron, Delany & Hiller, 2015). Schwartz et al. (2017) found that patient trust and empathic understanding was correlated with improved clinical management of glucose levels in patients with diabetes. The ability to learn and implement the person-centered approach has been correlated to positive treatment adherence, patient satisfaction, psychological well-being, improved physical function, and improved health status (Fuentes et al., 2014).

This study sought to add to the current body of research by conducting a phenomenological study investigating physical therapy student perceptions and development of the person-centered approach. Specifically, this research addressed whether physical therapy students understood the significance of the person-centered approach. This study further explored and identified prevalent themes that contributed to student understanding of the person-centered approach.

What has not been completely examined is whether physical therapists learn the value of the person-centered approach, and the skills needed to employ the technique, while students still engaged in professional education. Is the person-centered approach a technique learned in practice, or is it transmitted and received while still a student? Few studies exist to ascertain student understanding of this important construct. This study sought to answer the research question: "Do physical therapy students

understand and implement the person-centered approach and, if so, where and when is this understanding developed?"

The principle researcher had a tangential relationship with the subjects in this study through his participation in a campus research group. This inter-professional group of faculty researchers and students from a college of varied health professions educational programs included some of the subjects and their classmates. The issue of the person-centered approach became a topic of discussion within the research group and fueled our interest in this line of inquiry.

The principle researcher is a faculty member in the department of social work. His interaction with physical therapy students and educators has grown with his involvement in the interdisciplinary research group. He had been a psychotherapist for 28 years prior to his current position in academia.

Methods

Research Design

This research investigated physical therapy student understanding and development of the person-centered approach using participant interviews and observation. This study employed a phenomenological research design. Phases of data collection evolved and shifted as the interviews were conducted. The key idea was to learn about the development of the physical therapy student understanding of the person-centered approach. The study's research method utilized systematic data analysis procedures, as described by Creswell (2013), to assess the participant experiences.

Setting

Nine doctor of physical therapy students were chosen through purposive sampling because the inquirer sought subjects who could purposefully inform an understanding of the research topic. The research setting was a university department of physical therapy located in the Mid-South region of the United States. The university offers physical therapy education as part of the college of nursing and health professions. The principle researcher had no academic influence with the participants. Thirty to sixty minute interviews were conducted with each of the participants.

Participants

The participants included 6 females and 3 males. Their ages ranged from 23 to 46 years. There were 7 Caucasian students and 2 minority

students. Each was asked to describe his/her understanding and skill development of the person-centered approach. A list of meaningful, significant, and important statements of the participant experiences emerged from the research data. The participants were third-year students who were interviewed before completing their last clinical rotation before graduation. The class size was 27 students with an average age of 27.5 years. The nine participants were similar to the overall class demographics. The department of physical therapy was chosen as the setting for the study because of interest in the person-centered approach, physical therapy practice, access to physical therapy students, and therefore its convenience. Moustakis (1994) defined the criteria for the participant selection: Experience of the phenomenon, an interest in the topic, a willingness to participate in interviews and follow-up interviews, willingness to partake in recorded interviews, and a willingness to contribute to published data.

Data Collection

Institutional Review Board for Human Subjects approval for the protocol was obtained. Participants were informed of the purpose of the study. Each participant accepted and signed the consent form that described the purpose of the study, any possible risks, the choice to end participation without any consequence, the estimated time to complete the interviews, and intent to publish the data.

The nine doctor of physical therapy students were interviewed using a semi-structure interview technique. The interviews were transcribed and the participants' subjective statements and verbatim quotes were analyzed for emergent themes using the Modified Stevick-Colaizzi-Keen Methodology (Creswell, 2013). To maintain rigor, each interview was conducted by the first author, who is not a physical therapy faculty member and shared no academic relationships with the participants. The transcribed data was reviewed by another author to assure a level of objectivity.

The interview questions were broad and general so that the participants could construct meanings without being influenced by the researchers. Short, open-ended, clearly worded questions provided for detailed responses and exploratory questions allowed for specific responses. Follow-up questions explored narrative accounts, overall understandings, specific experiences, accounts of events, significant occurrences, and clarification of contradictory statements. The interviews ended when the information was saturated and no new information emerged. Verbatim quotes drawn from the interviews were used to provide evidence for the statements.

Data Analysis

Data analysis included the following specific steps. Epoche and bracketing, setting aside the researcher's experiences, and addressing the primary researcher's experiences with the phenomenon. After bracketing personal experiences, the participants' transcripts were read several times. The purpose was to gain an overview and acquire understandings of participants' statement (Creswell, 2013).

The second step created a list of meaningful and important statements taken from the participants' interview transcripts. Tactics for this step incorporated horizontalization leading to meaningful statement development. Horizontalization treated each statement with equal importance and consideration. It considered every expression with relevance by granting the same weight as other statements. This step included reading and rereading the transcripts while sketching ideas, writing notes in the margins, describing reflective thoughts in the transcripts and highlighting certain information deemed important. Pivotal events, emotion-laden statements, the understandings that mattered most and those that presented a clear understanding of the person-centered approach were identified. Interesting or unusual conceptual data were also recorded. At the end of this step, a pattern of meaningful statements was created (Moustakis, 1994; Creswell, 2013).

The third step consisted of developing clusters and categories. Developing themes included observing patterns of commonality and uniqueness for each specific participant's transcript and then across multiple transcripts. Significant statements were cultivated into themes by analyzing how phrases and sentences related to the research question. Themes described the meanings for the participants which mattered the most such as key objects of concern, relationships, processes, events, and values. The researcher continued to journal descriptive core comments.

The fourth step was to cluster organized themes into categories by noting how one theme related to another theme. The number of participant theme citations was an indicator of their interest in a particular theme. Specifically, initial categories emerged by sorting through the data base regarding similarities, consistencies, and the researchers own reflections about the participants' statements. This step's objective was to see how the themes fit together, which was the goal of the overall research question (Moustakis, 1994; Creswell, 2013).

Step five consisted of developing a structure or frame for illustrating the relationships between themes. This step constructed a sense of the whole

experience, which required examining each participant experience from the different themes (Moustakis, 1994). Step six addressed a structural description of the meanings and an essence detailing how the participants experienced the phenomenon of understanding of the person-centered approach. The last step captured the common experiences of the participants and the underlying structure of the participants' understandings. Participants were given the opportunity to review their representation for accuracy (Moustakis, 1994; Creswell, 2013).

The qualitative interviews were based on coauthoring by the participants and the researcher. Various audits enhanced the quality of the interviewing process. Member checks ensured that the transcribed data matched the constructed participants' the person-centered approach understandings (Smith, Flowers & Larkin, 2009). Peer debriefing included meeting with a colleague to review implementation of the research methods. This provided feedback concerning accuracy and completion of the research's data collection and data analysis procedures (Seidman, 2013).

Results

The modified Stevick-Colaizzi-Keen methodology was used for effective research analysis and answering the research question (Creswell, 2013). Four main themes emerged and represented the participants' experience with the person-centered approach and physical therapy. These descriptions of the participants' understanding and skill development of the person-centered approach allowed unique dissimilarities and common themes to unfold. The following section highlights the themes with verbatim quotes used to describe each theme. These themes depict the essences of all nine participants.

Theme 1: Physical Therapy Education Was a Critical Decision

Entering a doctor of physical therapy program was a crucial decision. Seven of the nine students had entered their program after establishing other career pursuits. The participants described their life trials and tribulations that contributed to their understanding and development of the person-centered approach.

> I never wanted to see another college campus again. I am a nontraditional student in many ways. I have more of a background in therapeutic alliance and qualitative research than most people who find their way to the medical professions. I ran a business and did public relations, office managing, customer service and the whole gamut of things

> that happen in business. I have interacted with a number of people and a number of different life situations. I lived out of the country for several years, then spent time working with refugees. Initially, I just wanted to help people and be in the helping profession. This program was a huge jump for me and had a large impact on my life. I didn't know what I really wanted until I wound up here. Most of my classmates may be younger but my experience has equipped me for connecting with people, understanding their situations, knowing who I am and being genuine . . . empathizing with their current challenges.
> (Eighth Participant)

Interacting with people from many different employment situations prepared the students to engage the person-centered approach specifically empathic understanding. Reflecting and utilizing their prior life experiences allowed the older students to engage with clients with a more fluid empathic understanding and genuine manner. The ability to draw upon prior life encounters resulted in more comfortability with the person-centered approach. Seven of the nine participants possessed interpersonal and employment life experiences prior to entering the physical therapy department. They held diverse prior employments such as personal trainer, waitress/ server, sales associate, gym assistant manager, marketing assistant, and customer service. The route to physical therapy education program was different for each participant. However, some instrumental dynamics were common for these participants. These included a desire to help people, the attraction of physical healing, and interest in engaging people. These experiences assisted the student participants to construct understandings and use of the person-centered approach.

Theme 2: Empathy is the Essential Feature

Eight of the nine participants reported using empathy as part of the person-centered approach to portray a caring and understanding interaction with their clients. When asked to rate the benefit of the person-centered approach, specifically empathic understanding in physical therapy, on a scale of 1-10 with 1 as the highest and 10 as the lowest, 3 participants rated the person-centered approach as 1. Six of the participants rated the person-centered approach and empathic understanding as a 2 or 3 because they felt that the technical aspect of having foundational knowledge and skills was slightly more beneficial for developing practice competency as a physical therapist.

> It is important to relate to the patients. The first step to build it[empathy] is to just listen and take into account what they have to say, and empathize with their situation . . . Then what can I do after that is help them understand other life factors that impact their recovery and help them get the best care possible. . . I am there to help with their physical injuries but letting them know I am on their side. It helps them follow through with their physical exercises and recovery if I can empathize. I believe what physical therapists do makes a difference in the patient's overall health and also believe in understanding and empathizing holds a lot of value. Time should be dedicated to this. So a patient might be sore but if they don't see that you care, they might not tell you and not give it their best effort. I had one patient who refused to do anything, we couldn't even agree on goals . . . Until I tried to understand their perspective. They are not just a number so I can receive a paycheck. He or she is a real person that needs to be shown that I care more about them than I do just about my job. The therapy that I provide and the knowledge that I give the patient is going to be at the top of the list but it rated a close second. (First Participant)

The student participants revealed both a professional and personal application of empathic understanding based on their prior life examples such as challenging and difficult times when they needed unconditional positive regard. One student stated she struggled with her first research class. She worried that she might not be successful. It was then she sought support and empathic understanding from colleagues and classmates. When she felt care and acceptance, she was able to become more focused and determined with the encouragement of her classmates. In addition, she was able to draw upon this experience to construct her approach with certain clients who struggled. She identified this as most beneficial for her skillset.

Theme 3: Exposure to Connecting with People

The last year of the program enabled the participants to enhance and develop their skills. They were able to discuss difficult case scenarios, consult with expert faculty, and scrutinize multiple treatment options. This participant described his experiences with learning the person-centered approach while seeing clients:

> We have one last clinical before we graduate and I want to make the best of it. I have been through other clinical rotations and each time I learned something different. I'm

> glad we are talking about this. I remember my last clinical instructor stated that we needed to connect with and understand our patients before we start showing them what to do. At the time, I really didn't know what she meant until I had one patient almost yell at me because of her pain and the manipulations we were doing. It suddenly dawned on me that I was treating her as simply a patient and not a person. My instructor pulled me aside and reminded me that everyone who is here [her clinical rotation site] is a uniquely different person. Some may be pleasant, willing, easily engaging and then some may be grumpy, disagreeable, and resistant. It's my job to connect with a degree of warmth and empathy to where they are psychologically. I finally got that, the end of my rotation. The light bulb went off . . . finally. (Third Participant)

This participant cited the importance of collaboration with her supervisor/instructor. She presented with a non-assertive approach and needed some initial encouragement to start. However, she seemed to grasp the benefit and usefulness of the person-centered approach specifically when her site instructor prompted her to use care, empathic understanding, and genuineness to guide her interaction with a client. Seven of the nine participants were able to identify examples of their client outcomes that were improved by use of the person-centered approach. Both personal exposures and professional encounters during clinical rotations had an influence on their skill development.

Theme 4: Integration of Participants' Understandings

All nine participates had a basic understanding of the person-centered approach. Six could relate specific examples of applying the person-centered approach significantly impacting their approach with difficult to treat clients:

> We were given articles and case examples in class but our clinical rotations impressed upon us the need to really connect and understand our patients. I had this one patient. When I walked in, he immediately sabotaged doing anything. No matter what I suggested, he rejected it. He had triple bypass, diabetes, knee replacement, no family support . . . He had a lot going on. He was like in that movie Grumpy Old Men . . . However, I remembered our CI [Clinical Instructor] stating that some patients need to vent, be heard,

> and then understood, before starting our techniques. So, I asked if he wanted a cup of coffee and he said yes, plenty of cream and sugar! Then we chit chatted about where his life had been recently and the challenges he was now facing. Next session, he agreed to get up and try. I needed to establish a relationship with warmth and empathy. You want to be understanding . . . Their opinions are important because the more of a role they can play in their therapy. You don't have that trust base on being genuine, then, you don't have that relationship and as physical therapist, we spend more time than doctors with our patients. So, we do have more opportunity to build relationships. That gives us an advantage to make productive changes. (Seventh Participant*)*

This theme focused on the status of the relationship between the physical therapist students and their clients. The participants emphasized that effective trusting collaboration was needed to form a positive alliance. When this was established, they were able to overcome resistance, ill-tempered and challenging clients. The participants who were able to utilize the person-centered approach when treating clients, were able to recall specific professor and instructor's suggestions regarding care, empathic understanding and genuineness. This often occurred in the heat of the moment, when first challenged by an irritable client. These circumstances led to the student participants integrating their understanding of the person-centered approach.

Discussion

The major themes identified from the student participant interviews described their understandings and development of the person-centered approach. Considerable research has been dedicated to the practice of physical therapy and empathic understanding approaches but few have addressed physical therapy student understanding and development of this important aspect of practice (Greenfield et al., 2017). Zhu (2016) stated it would beneficial to create a person-centered learning environment. Although it is clear that future research is needed to fill the gap in more detail, this study did demonstrate that the person-centered approach is a construct understood by these nine physical therapy students.

Each participant brought a unique flavor to the research. These students who volunteered to share their thoughts possessed strikingly different cultural backgrounds and personalities that shaped the person-

centered approach understandings. However, their physical therapy education allowed their understandings to transfer to knowledge.

The first theme was the importance of choosing physical therapy as a career choice. Six of the nine subjects came to physical therapy education in something other than a straight line. It became clear from their respective comments that additional life experiences gained in this path to physical therapy school contributed to their desire to help and their ability for empathic understanding. Overall, there existed an ardent determination to complete their physical therapy education and to make the most of their final clinical rotations. This furthered their ability to grasp the meaning and application of the person-centered approach.

The second theme was understanding the value of empathic understanding. The nine participants all stated the value of caring with the person-centered approach, specifically empathic understanding. The participants described empathy as setting the foundation for techniques to be implemented. They rated this highly with their skill sets. This study found that care, empathic understanding, and genuineness bridged many difficulties that the students faced when first meeting with clients. These difficulties included client resistance, lack of motivation, lack of supportive family environments, and lack of energy and inspiration. The fifth participant highlighted this theme by stating "You can't have a caring atmosphere without including more than just your "treatment technique", you need empathic understanding." Five of the student participants related the benefit of sacrificing time to connect with their clients in person-centered approach. This leads to a more satisfying interaction with clients when the person-centered approach is understood.

The third theme was exposure to connecting with people. Josephson, Woodward, Kron, Delany and Hiller (2015) stated that physical therapy students at times struggle to master the skill of the person-centered approach. The participants were able to reflect on their client encounters as helping with understanding and integration of the person-centered approach. Several student participants cited their clinical instructors' suggestions to slow down their approach and utilize the person-centered approach aspects with their clients. The participants (Seven of the Nine) who cited this did so with great emphasis. The students highlighted not only bonding with clients but also enjoyed this connection. One student stated that it's not just a rotator cuff scheduled at 3:00 this afternoon, it is an actual person. The students understood that the person-centered approach holds an important place in their future practices.

The fourth theme was integration of participants' understandings. One interesting facet was that 2 students struggled to outline and describe

the person-centered approach. These two students were the youngest members of the participants. They held more concrete views and related the person-centered approach to teamwork as opposed to the process of care, empathic understanding and genuineness. The nontraditional students provided more vigor and depth with their comprehension of the person-centered approach. These students voiced sophisticated understandings and application regarding the meaning, purpose, and benefit of the person-centered approach in their clinical rotations. Students who possessed diverse employment and educational experiences prior to entering physical therapy education were able to adjust to client difficulties with more comfort and ease.

Although the student participants could not recall a specific class that addressed and taught the skill of the person-centered approach, most were able to initiate a basic understanding and application of this approach. The person-centered approach was commonly found in the curriculum and then readdressed during their clinical rotations. Dutton and Sellheim (2014) referenced this as the informal and hidden curriculum in physical therapy education. The emphasis during clinical rotations holds the most meaning for understanding the person-centered approach as it allows the students to practice it. Each learning stage was guided by clinicians in the classroom and also physical therapy clinicians during clinical rotations.

The student participants stated a need to establish a person-centered approach specifically with more obstinate clients. Overall, they described a significant impact with choosing their words and approaches with clients. The participants transformed their comprehension of the person-centered approach from the classroom and clinic into strategies for effective client engagement. As the participants developed expertise regarding the person-centered approach, they reported seeing greater value with the approach as a part of a comprehensive patient management strategy.

One critical piece for these participants occurred when they made the effort to demonstrate empathic understanding. The students were guided to understand the patient's internal frame of reference to overcome initial resistance. West and Cox (2014) highlight this by defining empathic understanding as the ability to imagine what it is like to walk in someone's shoes. Empathic understanding was understood as a construct but was created within the physical therapy relationship. The physical therapy clinical rotations provided the students the opportunity to practice the person-centered approach and not be confined to more biological models of care. Zhu (2016) described the person-centered learning classroom as supportive innovative student learning. The person-centered approach is a unique approach that physical therapy students can offer their clients during

today's culture of more technical approaches. Specifically, empathy enhances the professional interaction and greatly influences outcomes.

Study Limitations

Possible limitations include that the sample was taken from one university. Since the study included one program, transferability may be limited. The participants' characteristics closely matched the overall profile of the physical therapy students at this university. The sample selection enabled the experiences of participants to be explored but non responders may have expressed different views. Another limitation is that the study sample was small, although one third of this cohort was included. The results of this study provide a rich description for possible future educational experiences.

Implications for Future Research

Physical therapy educators need to explore ways to facilitate student understanding of best practices for promoting patient education. The student participants were studied at one point in their academic education. It may be beneficial to explore recent graduates' views of the person-centered approach. Also, using a mixed methods research design during different points of their education may yield considerable factors. A basic knowledge of the person-centered approach may improve client motivation, adherence, goal agreement, and most importantly client outcomes.

After carefully exploring and considering the comments made by these nine participants, the authors would offer the following strategies for implementing learning opportunities in the PT curriculum that could support skill acquisition related to the person-centered approach.

1. Initial coursework should include the concept and application of the person-centered approach. Even before students have developed technical skills related to treatment, this appreciation for interpersonal, helping relationships could be supported.
2. When used case-based approaches teach, problem-solving, requiring students to assess the degree to which development of the person-centered approach could have an impact on outcome might be included.
3. Upon completion of initial clinical experiences, students could be tasked to assess the degree to which the person-centered approach played a role in outcome for a given client. The same idea could be explored in a case where the person-centered approach might not have been fully developed.

4. In courses where clinical-decision making is being taught, students could be challenged to explore the literature related to the person-centered approach and discuss what research suggests is most effective. It might be helpful in this case to ask students to consider the Evidence-Based Practice Model and comment on how the person-centered approach speaks to respect for client values and preferences.
5. Students, typically those in the latter stages of PT education, could be challenged to interview a client and try and determine just how important (or not) the idea of the person-centered approach might be from the client's perspective.

This qualitative study uncovered the degree to which physical therapy students understood, applied and valued the concept of the person-centered approach. These students (7 of the 9) demonstrated that educational experiences intended to facilitate the understanding of the person-centered approach need not be specific to one course. Trainees are taught the detailed mechanics of physical therapy but also need to convey a deeper empathic understanding of the client's life. Their experiences suggest that a thematic delivery method in which the concept is reinforced throughout a curriculum may work as well as any specific and concentrated unit of instruction. Educators can apply these findings to advance deeper understandings of the person-centered approach in students' professional skill sets.

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Impacts of Affirmative Therapy and Person-Centered Approaches on LBGTQ Populations

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Abstract. *With the information provided by the Association for the Development of Person-Centered Counseling Approach conference, in addition to lectures and teachings of psychotherapists researchers using Carl Rogers perspectives; I will identify the overlapping person-centered themes, approaches and application necessary to successfully work with the LBGTQ population. As a member of the LBGTQ community, I will share my own opinion and experiences with this therapeutic approach to exemplify its impact on my view of the therapeutic community's use of Affirmative Therapy, as well as explain the benefits for future use serving the LBGTQ population.*

Keywords: 19 Propositions, Affirmative Therapy, and LBGTQ, Person-Centered

Introduction

As a current counselor and student at Kutztown University, I have been able to develop a deeper appreciation and understanding of person-centered therapy and psychotherapeutic approaches on the Lesbian, Bisexual, Gay, Transgender, or Questioning (LBGTQ) population after attending the Association for the Development of the Person Centered Approach or the ADPCA conference this semester. One particular conference lecture on *Using Person-Centered Approach with LBGTQ Adolescent Clients* given by Fatemeh Dehghan Manshadi (2019), focused on encouraging the counselor to provide the client with the three core conditions, known as unconditional positive regard, empathy, and therapeutic companionship (congruence) when exploring their sexuality (Manshadi, 2019). Once these core conditions are established within the

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therapeutic relationship, psychotherapy techniques found in Affirmative Therapy can be introduced. Coincidently, these conditions nicely overlap with Rogers's theory of the 19 propositions of self-realization. This lecture inspired me to continue to educate myself on how this approach can benefit the LBGTQ population and encourage healthy therapeutic change within these clients. Afterward, I collected information from articles and books that offered data on Affirmative Therapy and provided suggestions on how the person-centered model could be integrated within this approach for a stronger theoretical application when working with LBGTQ clients.

Person Centered Approaches and Affirmative Therapy

The LBGTQ lecture by Manshadi (2019) defined the discovery and exploration of one's sexuality in six distinct phases including 1) Identity confusion, 2) compared heterosexual identity, 3) identity tolerance, 4) sexuality insight, 5) pride for their homosexual identity, and lastly 6) self-actualization. She states that the counselor's job is to encourage trust, build equality through unconditional positive regard, and develop empathy. The creation of a safe atmosphere in which the client works through the six phases of their sexual identity distinction is the counselor's most important task (Manshadi, 2019). This belief reinforces the foundational teachings of the person-centered approach where the client is ultimately responsible for directing the therapy session (Rogers, 1957).

Again, we can see the importance of the person-centered approaches taught by Rogers in another psychotherapeutic approach known as Affirmative Therapy. Recommendations for the use of this psychotherapeutic approach echo many of Rogers' ideas. One research article by Hinrichs and Donaldson, (2017) expresses that Affirmative Therapy is used to advocate and validate the self-identity and sexuality of the client. Naturally, this outcome cannot be properly achieved without the use of Rogers' six core conditions. The research based off the Affirmative approach states that the counselor should use techniques such as active listening, healthy expressions of human connection, and enhance the therapeutic relationship by understanding the sexism, biases and discrimination the LBGTQ population might experience (Hinrichs & Donaldson, 2017). Thus far, we have seen how Affirmative Therapy utilizes the basic principles of Rogers' person-centered approach and will next explore the incorporation of Rogers' 19 propositions into the application of Affirmative Therapy.

Rogers' 19 Propositions and Affirmative Therapy

When comparing Rogers' 19 propositions and Affirmative Therapy, the similarities regarding client change are front and center. The most

vibrant similarity that is found in both the basic idea of Affirmative Therapy and the 19 propositions is the goal of helping the client reach their full potential and develop a deeper understanding of the self (Rogers, 1951). Collectively, the 19 propositions and Affirmative Therapy also promote clients to reach an understanding of external and internal values, world perception, experiences, and bring awareness to incongruences in their lives (Rogers, 1951). The combined efforts of the client and counselor to work on these 19 propositions through a person-centered approach are also encouraged within the Affirmative Therapy model. The Affirmative approach will encourage the client to question their personal attitudes and beliefs regarding sexuality, gender, spiritual connections, defining their own resilience, and question pervious world perceptions regarding homosexuality. The blend of these approaches will inspire increased self-worth in the client, and also promote diversity and understanding in the client's worldview. The hope is that these changes support the client's acceptance of their sexual identity and foster development of pride surrounding it (Hinrichs & Donaldson, 2017).

Affirmative Therapy focuses on the growth and development of a client's understanding of sexual identity, and, like the person-centered approach, supports a holistic view of understanding human connection (Hinrichs & Donaldson, 2017). Through the 19 propositions, clients are encouraged and challenged to reevaluate their external and internal perspectives on sexual identity and orientation. This is where the application of Rogerian techniques can take root within Affirmative Therapy. Researchers suggest that Affirmative Therapy tools and techniques are great ways to assess individuals struggling with their sexuality or gender orientation. However, focusing solely on the exploration of sexual identity can be limiting to the client's overall therapeutic experience (Moradi & Budge, 2018). Researchers Moradi and Budge (2018) highlight the importance of recognizing the multiple dimensions of this experience. These authors urge the therapist to give a client ample space to describe themselves beyond predetermined categorizations of sexual identity, attraction, or behavior (Moradi & Budge, 2018). By maintaining the Rogerian perspective, therapists can provide an enriched experience where clients understand how their sexuality fits into a holistic and compassionate view of the self.

Application of Affirmative Therapy with Rogerian Techniques

In the book *Affirmative Counseling with LBGTQ plus people*, authors Ginicola, Smith & Filmore (2017) discuss how Affirmative Therapy is not a specific treatment protocol but rather a collection of collaborating

ideas that focus on awareness, support, oppression, and privileges LBGTQ people might experience. The Affirmative ideas addressed with clients can be broken down into six categories including 1) understanding self-awareness and identity, 2) understanding cultural competency, 3) shame and guilt, 4) spirituality education, and 5) self-advocacy (Ginicola et al., 2017). It is through steps 1, 3, and 5 where I can see person center therapy being best utilized and the six core conditions being implemented into a client's treatment. It is here that counselors can guide clients through an intimate experience of unconditional positive regard and empathy. Counselors should exhibit understanding when exploring a client's struggle with shame, guilt or incongruencies that relate to bias in sexuality issues. Only then can clients see the counselor's unconditional positive regard or acceptance of their experiences. This atmosphere will likely be motivating for the client's self-advocacy of their sexual identity or orientation.

Once this congruency and relationship is cemented between the counselor and client, the counselor can educate the client on Rogers' 19 propositions and explain ways in which they can be manifested into the client's own reality, behaviors and experiences, in-order to address inconsistency or anxiety regarding sexuality. Once the counselor has walked the client through the 19 propositions, the client has reached their goal of adopting a newly-structured and valued perspective of their world. They are reassured of their own self-identity and feel more centered when confronted with societal biases, stereotyping, and disordered thinking. Lastly, it is important to note that Affirmative Therapy provides multiple assessment tools to help clients achieve congruency throughout this process. Researchers Moradi and Budge (2018) have several assessment tools that address client's self-efficacy, attitudes, and false beliefs and behaviors towards LBGTQ topics. Through these steps and perspectives, it is clear that the fundamental tenets of Rogerian theory are at the heart of Affirmative Therapy. With continued research and application, Affirmative Therapy theory can develop from its current infancy, into a broad contribution to the field of counseling.

Future Direction

The future of Affirmative Therapy is still widely undetermined. Researchers Moradi and Budge (2018) urge the importance of developing more research with underexamined LBGTQ populations. They conclude that a meta-analysis of their research using Affirmative Therapy assessment tools shows a high concentration of cisgender male with HIV as the basis of their study. They acknowledged the lack of women, transgender individuals, and openly gay individuals partaking in their research and

encourage that research teams develop new strategies to provide more diversity in future studies (Moradi & Budge, 2018).

As stated earlier in *Affirmative counseling with LBGTQ plus people*, author Ginicola et al., (2017) expressed that the major critique of Affirmative Therapy is that it does not yet have a concrete identity within the counseling field and that it needs a solid foundation of research to do so. There are countless examples of the benefit of Affirmative Therapy and its measurement tools for clients to develop more self-empowerment provided by Moradi and Budge (2018). Their meta-analysis, however, highlights their awareness of the limitations of sexual identity liberation provided by this theory. To create lasting change, we must first educate and encourage counselors to become more aware of cultural competency regarding LBGTQ client issues. The ADPCA conference was a fantastic resource for education as it provided its attendees with an introduction to Affirmative Therapy through the lens of the widely used person centered approach. The ADPCA conference, however, cannot be the only way to cultivate interest and expansion of this theory. Perhaps conducting research on specific LBGTQ populations such as those struggling with addiction, family, or mental health issues can help strengthen the validity of this theory.

In my experience with the research presented on Affirmative Therapy, and maintaining the foundation provided by Carl Rogers, I was able to witness for the first time at the ADPCA conference at Kutztown University a successful therapeutic model for the LBGTQ population. This community has been widely misunderstood and ignored for far too long. This experience provided me with an optimistic view for this theory's future contribution to the field of counseling. As a member of the LBGTQ population, this is the type of therapeutic approach I feel would have benefited me when I was discovering and processing my own sexuality. My experience at the ADPCA conference was not only refreshing, but it also instilled in me a long-awaited hope that LBGTQ individuals will be better served in the mental health field going forward. It was the innovative ideas of Carl Rogers and his influence on Affirmative Therapy that I have to thank for that.

Conclusions

Throughout human history, minority populations have struggled to gain a voice and the LBGTQ population is no different. Only through the evolution of our own diversity have we managed to help such populations feel included and understood. It is in a combination of Carl Rogers' person centered ideas that other psychotherapeutic modules such as Affirmative

Therapy can grow in order to serve individuals who struggle with the sigma and discrimination attached to homosexuality. Both Person Centered Therapy and Affirmative Therapy have done what most other popular therapy modules have failed to do, which is given the client a voice. The client can now express their therapeutic needs in a safe environment where they are free from judgment, experience empathy in their struggles, and receive guidance to blossom into the best versions of themselves. Thanks to the ADPCA conference, there is proof that progress for diversity in the field of counseling is obtainable. My hope is that with the seeds Carl Rogers has planted with his 19 propositions and six core conditions, we can see the therapeutic field grow and expand beyond Affirmative Therapy to provide future clients with an accepting and holistic worldview.

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An Interdisciplinary Perspective on Meteorological Learning for Person-centered Psychotherapists Facing Earth's Changing Climate and Everyday Weather

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Author note: Bolton was supported academically during the period of this work by a U.S. National Weather Service-sponsored and American Meteorological Society-awarded Graduate Fellowship. The opinions, conclusions, and/or recommendations expressed here are those of the authors and do not necessarily reflect the views of the National Weather Service or American Meteorological Society.

Abstract. *This paper presents an interdisciplinary, person-centered perspective on the need for, and resources to enable, meteorological learning among humanistic and other psychotherapists.*

Ecological and environmental psychological perspectives on the person-centered psychotherapeutic approach are not new (see, e.g., Blair, 2011, 2014; Neville, 1999; Stouder, 2014; Tudor, 2014). However, they are becoming ever-more important as the Earth's weather regimes continue to shift toward extremes. Recent data[i] and computer model predictions[ii] have indicated, to showcase just a few emerging trends, that in the years to come society will face hotter temperatures; larger, more frequent droughts and wildfires; more or less rain, depending on location; and tendencies for

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greater numbers of tornadoes and stronger tropical cyclones (Intergovernmental Panel on Climate Change [IPCC], 2018).

What's more, a growing coastal population means that even without weather and climate changes, individuals in particular locations may be subjected to certain adverse outcomes (e.g., coastal flooding, tropical cyclone landfalls–one need only briefly look at a nighttime GeoColor satellite image to see just how densely populated the Florida coastline has become). In other words, the climate's natural variability may increase to extreme levels and translate, due in part to interaction with other factors, to increased negative weather/climate-based impacts on physical, economic, and/or mental health.

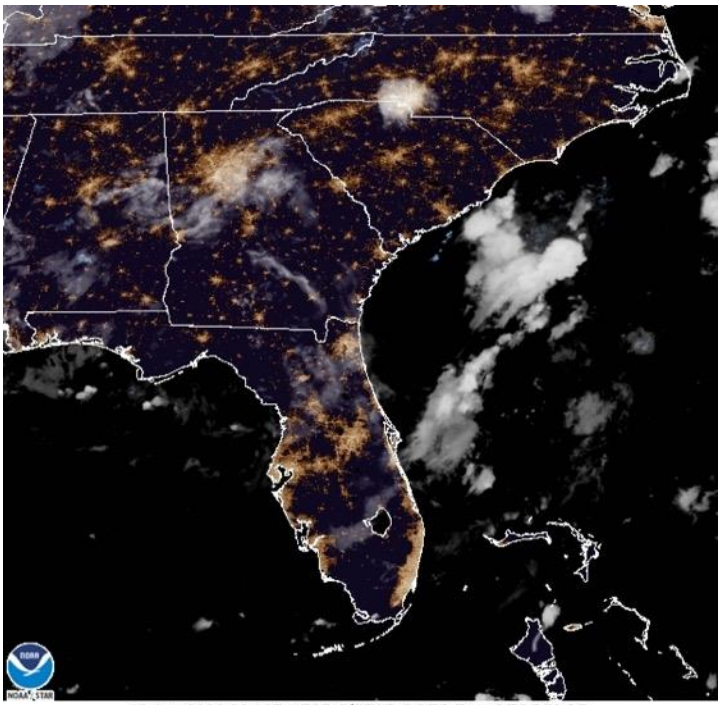

Figure 1. NOAA/NESDIS GeoColor Satellite Image for August 12, 2020, 09:11 UTC.

It is with this background context in mind that we want to provide an interdisciplinary perspective on the need, and resources and recommendations, for humanistic psychotherapists to more formally become familiar with meteorology and climatology topics on at least a basic level. Note that elements of this perspective might be beneficial to other therapists as well, given the wide applicability of person-centered principles within the therapeutic relationship and across modalities (Rogers, 1962; Wampold, 2019). If current environmental predictions verify, psycho-therapists will be essential first-responders in the fight against climate change and extreme weather, and they need to be adequately equipped to help others with psycho-meteorological difficulties.

A Person-centered View of Human-Weather Interactions

Since their earliest days, person-centered views have been rooted in the therapist's striving for a holistic consideration of the entire person and the belief that individuals have a natural tendency towards growth. Perhaps the most heralded person-centered characteristic aside from these, which quickly differentiates the family of person-centered approaches from other psychotherapy modalities, is non-directiveness and the associated, synonymous belief that the client is his or her own expert in experiencing the world. Hence, the client should not have treatment dictated or driven by the therapist but rather by his or her own self-learning and exploration.

These principles have informed not just a therapeutic modality but a manner of existing in many areas of life (e.g., Henderson, O'Hara, Barfield, & Rogers, 2007; Proctor, Cooper, Sanders, & Malcolm, 2006; Rogers, 1995a). Bolton (2020), Bolton and Mogil (2020), and Mogil and Bolton (2019) provide similar insights on person-centered mentorship. The principles inherent to person-centered approaches justify and encourage the person-centered therapist's meteorological education, useful in treating clients with a range of environment-related issues–including climate change anxiety and grief, weather fears, and more clinically-presenting phobias (the latter two of which are included within the American Psychiatric Association's *Diagnostic and Statistical Manual* specific phobia, natural environmental classification; Choy, Fyer, & Lipsitz, 2007; LeBeau et al., 2010).

Other therapeutic modalities have developed understandings of meteorological phenomena to better facilitate client healing and coping. For example, cognitive-behavioral approaches have been used to treat seasonal affective disorder (Rohan, Tierney Lindsey, Roeklein, & Lacy, 2004; Rohan et al, 2007; Rohan et al. 2015) and both thunder (Barkham & Hobson, 1989; Matthey, 1988) and winter storm phobias (Wang, 2000). Cognitive-behavioral perspectives have been influential, as well, in discussions of both sub-clinical and clinical weather anxiety and phobia (Coleman, Newby, Multon, & Taylor, 2014; Greening & Dollinger, 1992; Lonigan, Shannon, Taylor, & Finch, 1994; Watt & DiFrancesantonio, 2012; Westefeld, 1996; Westefeld, Less, Ansley, & Yi, 2006). Meanwhile, Stewart (2007a, 2007b) provided an Adlerian perspective for understanding human-weather-climate interactions; and Weintrobe (2012), among others, provided a psychoanalytic perspective.

Non-directiveness grounds person-centered therapists with a highly unique perspective on human-weather interactions. For the classical person-centered therapist, therapy sessions are not about re-shaping the client's anxieties or cognitive or behavioral aversions–nor are they about

sensitization, exposure, body relaxation, mindfulness, or among other tools the challenging of some belief. Rather, they are all about providing an environment for safe psychological contact (with the therapist, but also with one's self), in which the client feels empowered to formulate for him or herself new internal meanings and schemas for the altering of attitudes, self-concepts, and behaviors. Further, psychological techniques in person-centered therapy–the uses of simile and metaphor and the gentle, careful inviting of the client towards and through difficult emotions–are engineered to suggest, not set concretely in stone, new meanings and understandings which the client may accept or modify into, or reject from, his or her self-structure (the individual's inner cognitive schema for the way the world works; Tolan & Cameron, 2017).

Just as specialized knowledge of client processes associated with sexual abuse (Hawkins, 2014), autism (Rutten, 2014), and dissociation and psychosis (Warner, 2014), among other conditions, can powerfully strengthen the therapeutic relationship, it is *because* person-centered therapists, including those who are somewhat more directive,[iii] desire to facilitate the client's own self-striving for growth that their learning of meteorological concepts and contexts is essential. After all, the lives of both therapists and clients occur within and under the weather's influence. Examining our existence within the atmosphere's scope and influence, as a phenomenological and personally-significant event (Kelly, 1955; Stewart & Blau, 2019; Stewart & Oh, 2019), may lead to greater self-awareness of the foundations of our own being and allow change to better take place within the client.

The therapist's success fostering congruence, a sense of mutual genuineness, with the client is predicated on achieving what Rogers called "a sensitive empathy" (see Rogers, 1995a, pp. 142-145). One cannot properly understand the client's experience as an expression and personification of his or her presenting feeling or mental state (Rogers, 1995b) without conceptual awareness for that psychological phenomenon. So too is it with meteorological stimuli, which might present as psychologically troublesome in-session. That's just one reason we have begun theorizing, from an emotion-focused therapy perspective, about trauma responses among meteorologists (Bolton, Stewart, & Mogil, 2020). Such knowledge informs mental healthcare for meteorologists and others as well; just one benefit is that it allows the person-centered therapist to formulate more effective and appropriate similes and metaphors which are sensitive to the potentially traumatic nature of dangerous weather events. For example, one may avoid or more appropriately tailor such statements as "*you just felt flooded*" or "*it was like a whirlwind of emotions*," to describe a client's experience of overwhelming feelings.

Moreover, it is important for psychotherapists to possess conceptual awareness and understanding so that they themselves are not frightened or overwhelmed by the client's presenting problems and so they can understand how to best be of help. This cannot be underscored enough, for it is only when one fully understands a thing that it can be properly symbolized in awareness and integrated or re-integrated into one's self-structure. This applies to the therapist as well as the client. Meteorological elements severe enough to be dangerous and, therefore, psychologically troubling, are often traumatizing. Hail stones which pummel vehicles, leaving them "totaled;" near-miss, cloud-to-ground lightning strikes and loud thunder; violent tornadoes which rip even well-secured buildings off their foundations; hurricanes, which can leave entire towns and cities devastated through combined torrential rains, strong winds, and flooding– not to mention the occasional tornado. All of these weather elements (and others) can significantly tear into the substrate, the fabric, that is one's sense of being in the world: Through them, the individual's self-structure and experiences of the world become dis-integrated, leaving the person psychologically unbalanced as well as possibly physically displaced.

Recent climatic change has heralded in a series of psychological problems related to perceptions of changing, long-term weather patterns (see Swim et al., 2010, and Doherty & Clayton, 2011 for a broad overview). Thus far, psychoanalytic perspectives have dominated theoretical conversation around this topic. Climate change-related grief (Albrecht et al., 2009; Bourque & Cunsolo Wilcox, 2014; Cunsolo & Ellis, 2018), characterized by an abiding distress for perceived threats to one's natural environment and ecosystem; and climate change-related anxiety (Clayton, 2020; Clayton & Karazsia, 2020; Searle & Gow, 2010; Stokols, Misra, Runnerstrom, & Hipp, 2009; Wandersman & Hallman, 1993), alongside other emotions like despair (Randall, 2009; Weintrobe, 2012), are two sets of psycho-meteorological stressor. Denial and avoidance play, with these, into a motivated apathy for climate change (Lertzman, 2017; Moser, 2007).

To take an emotion-focused perspective, such primary emotional responses as these, followed by secondary numbness, are characterized by habituation to the "drumbeat of news about various overwhelming environmental and societal problems" (Moser, 2007, p. 68; Schinko, 2020; Verplanken & Roy, 2013) that prevent individuals' learning about and responding in an informed manner to climate and weather threats. Although we may learn to react to weather- and climate-related news and even to weather events, how much do we really *know* about our own inner, phenomenological experiences of ordinary, sublime, and severe and dangerous weather events? Are we fully in touch with and can we readily

identify and cope with our emotions and mental states that arise due to changes in the weather and climate patterns?

Yet a third reason for this overall discussion is the need for greater awareness of the mental health impacts that can occur for individuals *working* in the earth and atmospheric sciences (Bolton & DePodwin, 2019; Bolton et al., 2020; Gilford, Moser, DePodwin, Moulton, & Watson, 2019; Tucker & Horton, 2019). Mental health matters to meteorologists, too. Anecdotal discussion with meteorologists at professional conferences and elsewhere has revealed, from some who take advantage of mental health services, that psychotherapists tend not to have an appreciation for the cognitively (and, often physically) taxing nature of the work meteorologists perform daily and around-the-clock. This lends itself to an overall weakening of the therapeutic relationship. A greater awareness for the workings of the professional weather workplace and particular strains and stressors of that workplace is paramount for therapists who might engage with meteorologists; it is the only easily-opened window into the meteorologist's mind.

Meteorological Education and the Psychotherapist

School-based education efforts often fail in the teaching of weather and climate science, according to Mogil (2018, public testimony to Collier County, Florida, Public School Board). Mogil, serving as an independent, community-based reviewer of K-12 science textbooks for Collier County Public Schools in its most recent textbook adoption cycle, found numerous scientific errors and omissions in the areas of weather and climate. He discovered an eroded presentation of basic atmospheric science principles and understanding of these, akin to the removal of grade-school geography in favor of other social science topics (Camera, 2015). Increasingly within educational efforts, he is observing a much greater emphasis is placed on "selling" the dangers of climate change, without an appropriate understanding of the background weather science. Mogil likens this understanding of climate, but not weather, to a brain surgeon who lacks an understanding of basic human anatomy and physiology.

For this reason, psychotherapists may be well-served in checking the meteorological comprehension of the client who presents with psycho-meteorological difficulties. Here, from the vantage point of working pluralistically and providing psychoeducation (Cooper & McLeod, 2011, 2019; Thompson & Vivino, 2014), they can work to ensure the client has a basic and appropriate understanding of weather and climate physical processes as they relate to the client's presenting problem. In our experience as weather learning facilitators (Bolton and Mogil) and as a psychotherapist (Stewart), an accurate understanding of meteorological phenomena

portends a lessening of weather-related fears. We have anecdotally observed, for example, that once the weather-anxious or phobic individual has a reasonably accurate perception for the way thunder and lightning work, they are perceived as less uncertain and scary and can be better integrated into the individual's self-structure. Bolton's own childhood experience with debilitating weather phobia, which turned to positive and passionate weather curiosity upon his learning of physical meteorological processes, also speaks to the curative effect of this type of processing.

It is important to note that online weather and climate websites, while often informative, can also be filled with erroneous information. This includes both social and mainstream media sources. Often, extreme or outrageous claims are designed to hype or sell the web link or media source, and photos of severe and dangerous weather phenomena are frequently edited to appear even more menacing and ominous. Distinguishing between reputable and unreliable information is not necessarily easy. This may be an important matter to address in working with clients doing "homework" between sessions.

How can such awareness–for dangerous weather phenomena, and for stressors of the meteorological workplace–be obtained? First, there are many accessible online resources that host credible, easily-digestible meteorological information for a range of knowledge levels. One of the best for general weather knowledge is the Jetstream website hosted by the U. S. National Weather Service (NWS; https://www.weather.gov/jetstream/). The NWS' Storm Prediction Center has excellent information pages for tornadoes (https://www.spc.noaa.gov/faq/tornado/) and derechos (long-lived, widespread wind storms typically accompanied by strong thunderstorms; https://www.spc.noaa.gov/misc/AbtDerechos/derechofacts.htm). A comparable wealth of information about hurricanes and storm surge can be found at the NWS' National Hurricane Center (https://www.nhc.noaa.gov/). Those looking for a deeper learning than these resources provide can engage with distance learning materials from several universities (see https://www.ametsoc.org/index.cfm/ams/education-careers/careers/career-guides-tools/distance-learning-courses/ for a listing maintained by the American Meteorological Society). Otherwise, exposing oneself to severe and dangerous weather situations through online video footage is a sure way to put oneself in the shoes of the weather-phobic or anxious client.

Finally, one can easily become more familiar with climate science. The first challenge in this regard is to recognize that climate and climate change educational material often fails to adequately differentiate the two

types of climate. There is a geographical climate, with reference to the places in which people and animals live and plants, trees, and other life exist; and there is a weather-related climate, with respect to the longer-term sustained averages of moment-to-moment weather happenings. *Climate change* refers to the long-term changes affecting both of these. As far as data is concerned, the NOAA National Centers for Environmental Information generally only consider weather-climate, and then, typically, in long-term trends ("climate normals") over the latest three decades. As of this writing, normals data exists for the U.S. for the 1971-2000 and 1981-2010 periods (https://www.ncdc.noaa.gov/data-access/land-based-station-data/land-based-datasets/climate-normals). An even longer-term climate analysis framework, taking both geographic and weather factors into account within categorization of world regions by weather condition and vegetation type, is the Köppen climate classification system (Beck et al., 2018; National Geographic, n.d.).

A second challenge in climate science education is the proliferation of denialist and skeptic beliefs about global climate change (Antonio & Brulle, 2011; Dunlap & McCright, 2011; Häkkinen & Akrami, 2014; McCright & Dunlap, 2011). We mention this because some who present in therapy, whether or not it is with psycho-meteorological difficulties, may have strong views on climate change. These, to a large degree, appear linked to political ideology (e.g., Dunlap & Jacques, 2013; van der Linden, Panagopoulos, Azevedo, & Jost, 2020), a broader belief in conspiracy theories, and lowered pro-social behaviors and acceptance of science (van der Linden, 2015). Those working through such topics with clients may find the work of psychologist Sander van der Linden helpful; he has conducted a substantial amount of research into climate change and misinformation beliefs and methods by which to counteract scientific misinformation, denialist beliefs, and skepticism.

The NASA climate website (https://climate.nasa.gov/), with its synthesis of informational guides, may also be helpful to both psychotherapists and their clients, while a more engaging method to learn about Earth's changing climate is to actually examine real data. One can access easy-to-read climographs for weather stations and readily observe historical change in various atmospheric conditions, both spatially and temporally (https://drought.unl.edu/Climographs.aspx; note, the University of Nebraska site has an international, as well as U.S.-centered, listing). Much other atmospheric data can be found at https://www.climate.gov/maps-data/datasets. In all of these meteorological and climatological learning facilitation circumstances with clients, familiarity with methods by which to effectively communicate numerical

and scientific uncertainty may be useful (van der Bles et al, 2019; van der Bles, van der Linden, Freeman, & Spiegelhalter, 2020).

To answer how one can become more familiar with the meteorological workplace, a quick and easy first stop is the NWS webpage at https://www.weather.gov/about/. One can "drill down" to learn about various aspects of the U.S. government's weather agency. To take things a step further, the interested psychotherapist could actually tour an NWS field office and witness forecasters "in action." The NWS webpage at https://www.weather.gov/ can be used to navigate to one's local forecast office webpage, where (typically email-based) contact info can be located in order to arrange such a tour. One may also reach out to local television meteorologists for tours of their facilities.

Many meteorologists are happy to engage with those interested in learning about meteorology and the nuances of the profession itself. There is also an expanding literature one can read: Sociologists Gary Fine (2010) and Phaedra Daipha (2015) have written accounts of the NWS workplace and psychologist Robert Hoffman and colleagues wrote the interdisciplinary *Minding the Weather: How Expert Forecasters Think* (Hoffman, LaDue, Mogil, Roebber, & Trafton, 2017), on much of the psychology that goes on in the NWS trenches. Television meteorologists Janice Dean (2019), James Spann (2019), and Ginger Zee (2017) have all documented their own lives–including deep dive discussions into the meteorological profession and related mental health matters. Other insightful books, on the phenomenological experiences of people who have lived through severe and dangerous weather, include:

Storm of the Century: The Labor Day Hurricane of 1935 (Drye, 2019)	*Storm Warriors* (Carbone, 2001)
Isaac's Storm (Larson, 1999)	*The Children's Blizzard* (Laskin, 2004)
Faces From the Flood (Moore & Barnes, 2004)	*Weather in the Imagination* (Boia, 2005)
The Cloud Collector's Handbook (Pretor-Pinney, 2011)	*Soul of the Sky: Exploring the Human Side of Weather* (Adler & Thurlow, 1999)
Storm Chaser: In Pursuit of Untamed Skies and *The Ultimate Storm Survival Handbook* (Faidley, 1996; 2006)	*Into the Storm: Violent Tornadoes, Killer, Hurricanes, and Death-defying Adventures in Extreme Weather* (Timmer, 2011)

Although the following films are based on "popular" conceptualizations and even myths, one can gain important insights as to the basis of client weather anxieties and phobias by viewing *The Day After Tomorrow*, *The Perfect Storm*, and *Twister* (in which one of the primary characters, brought to life by actress Helen Hunt, exhibits adult storm fascination and sensation-seeking behaviors related to storm chasing as a result of childhood tornado exposure). An insightful non-fiction documentary, about New Orleans during and after 2005's Hurricane Katrina, is *When the Levees Broke: A Requiem in Four Acts*.

Finally, it is important to be familiar with emerging research on the psychological functioning of meteorologists, particularly with respect to mental health and personality tendencies. Bolton, Ault, Greenberg, and Baron-Cohen (2018), and Bolton and Ault (2020) have explored the mental health and wider personality tendencies of meteorologists in two studies. The first (Bolton et al. 2018) examined broad between-groups differences in meteorologists' personality traits and mental health tendencies with respect to those of engineers and physicists. The workplaces and job-roles of engineers, physicists, and meteorologists are highly dissimilar. However, they were compared because another hypothesis tested links between meteorologists and autism, building on 20 years' worth of work linking autism and the physical sciences (e.g., Baron-Cohen, Wheelwright, Stott, Bolton, & Goodyer, 1997; Baron-Cohen, 1998; Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001; Baron-Cohen, 2015). This included testing links to general autistic-like traits as well as the empathizing and systemizing cognitive styles of autism.

The meteorologists were higher in empathizing and systemizing, extraversion, conscientiousness, and agreeableness, and less stressed, depressed, and anxious than the combined engineer/physicist group. This promisingly suggests meteorologists have a tendency toward a healthy personality profile (Bleidorn, 2018), and that meteorologists have a flexible, hybrid cognitive style that switches between empathic, intuitive and more rational, rule-based thinking (Brosnan, Hollinworth, Antoniadou, & Lewton, 2014). They also scored comparably, in terms of autistic traits, to the engineers and physicists.

The second study (Bolton & Ault, 2020) examined individual differences in trait personality, mental health, and subjective wellbeing across meteorological employment sectors. Television meteorologists were significantly more burnt-out at work and personally, were higher in extraversion, and were highest in anxiety. NWS meteorologists were most burnt-out in working with partners (i.e., those working in other areas of the meteorological community, such as television meteorologists and emergency management professionals). A miscellaneous grouping (a

combination of academic, private sector, military, and non-NWS operational meteorologists) showed more agreeableness and greater job satisfaction than broadcasters and those in the NWS. There was no cross-sector difference for traits that might be relatively uniform among meteorologists: Grit, life satisfaction, self-concept clarity, subjective happiness, stress, and depression. Altogether, this research begins to paint a picture of the meteorologist's psychological disposition, an understanding for which would be helpful to the psychotherapist.

Concluding Thoughts

As society mounts a defense against Earth's changing weather and climate patterns and even just everyday weather, it is important for psychotherapists of *all* modalities, not just those who are person-centered, to possess meteorological and climatological understanding for the benefit of the client. This paper therefore presents a person-centered view of human-weather-climate interactions, and resources, to enable therapists so inclined to effectively learn about the meteorological workplace as well as physical atmospheric processes and the human impacts of those physical processes (e.g., tornadoes, lightning, and hail).

Nonetheless, it possesses elements relevant to all psychotherapy practitioners wishing to provide more sensitive and nuanced care to those with psycho-meteorological difficulties and working within meteorology. The paper also presents resources enabling therapists so inclined to effectively learn about the meteorological workplace. These learnings, altogether, will allow therapists to work more effectively with clients who present with psycho-meteorological problems or problems–such as unique variations of secondary traumatic stress–that might relate specifically to the meteorological workplace We hope readers find this perspective insightful and will carry our ideas forward in discussion and debate.

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Therapeutic Change Factors in Alcoholics Anonymous

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Abstract. *The current study examines 52 counseling students' personal reactions to and observations of Alcoholics Anonymous (AA). Data are coded from narrative reports written by students in a family addictions class from 2012 to 2016. Over 40% of students reported holding a stigma about alcoholism. About half felt anxious regarding attending a meeting, not wanting to intrude. However, the vast majority, 90%, felt welcomed by AA group members, who altruistically imparted information to them (67%; n = 35). Students very commonly reported evidence of Belongingness and Cohesion in AA. Although the students' observations show that genuineness and empathy do not play a significant role in AA, positive regard was common. Nevertheless, high correlations between positive regard and statements of powerlessness and higher power suggest that positive regard in AA is conditional, and aligned with Step 1 (admitted we were powerless) and Step 2 (came to find a Higher Power could restore us). The current study supports referrals to AA for individuals who desire to stop drinking, are ready to take action, and are comfortable with the religious and spiritual aspects. This study supports the idea that although AA is not a substitute for counseling, it offers unparalleled socialization and support for a recovery identity.*

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Introduction

Estimates of the success of Alcoholics Anonymous (AA) in helping people achieve and maintain sobriety range from 10% to 50%, depending on the data source. One certainty about AA is that it has a strong and enduring track record of helping people reduce their drinking and drinking-related symptoms (Troyer, Acampora, O'Connor, Berry, 1995). Its success is seen across the continuum of care, including during withdrawal management, inpatient treatment, partial care, and outpatient counseling (Sifers & Peltz, 2013). In a comprehensive review of the literature by Kaskatus (2009), AA was shown to produce significant positive effects on alcohol use magnitude, dose-response, plausibility, and temporal accuracy.

The success of AA in helping multitudes of people with drinking problems creates an imperative for counselors to be open to AA as a possible treatment. Stigmas about alcoholism and AA, particularly among mental health providers, can limit AA as a resource for clients. The current study introduces counseling students to the AA program by assigning them to attend a group meeting, to explore their feelings and thoughts about attending, and to record their observations of AA group member behaviors.

Disagreements Between Client-Centered Therapy and Alcoholics Anonymous

On the surface, client-centered therapy (CCT) (Rogers, 1961) and Alcoholics Anonymous (AA) (Alcoholics Anonymous, 1939/1976) appear to be diametrically opposed approaches. CCT is process-oriented, and AA is outcome-oriented. CCT is non-directive, and AA is directive. CCT embraces subjective experience and rejects diagnostic labels, while AA accepts the disease model and freely labels people "alcoholics" and "addicts."

Shared Assumptions of Client-Centered Therapy and Alcoholics Anonymous

Despite their differences, CCT and AA share some important assumptions about change. One of these assumptions is that drugs prescribed to solve problems often produce (sometimes severe) iatrogenic effects. Ironically, AA may receive more criticism than CCT for rigidly holding an anti-pharmaceutical perspective.

Another shared assumption between CCT and AA is that participation in change should be voluntary. To this point, AA is seen to be best suited for people who believe they have a problem and want to stop drinking (Laudet, 2003). Likewise, AA is ill-suited for people in pre-

completion and contemplation stages of change (Prochaska & DiClemente, 1983). It makes sense that AA is ineffective if it is attended involuntarily, considering that the only requirement for membership is the desire to stop drinking. It follows that mandating clients to AA has been deemed not best practice (Monico, Gryczynski, Mitchell, Schwartz, O'Grady, Jaffe, 2015). Not only does mandating run counter to the idea of voluntary participation, but it begs the question of anonymity. However, the real reason that mandating AA fell out of favor is that it goes against the first amendment Establishment clause related to religious freedom (Jenkins, 2005). A California appeals court ruled that, "Court-mandated attendance in a theistic drug treatment program violates the Establishment Clause…,"and is a violation of civil rights (Wilson, 2014).

Indeed, AA's religious elements are a turn-off for many people. Many AA groups recite the serenity prayer and/or the Lord's prayer, and six of the 12 steps reference religious or spiritual concepts (Step 1 refers to "prayer;" Step 2 says, "power greater than ourselves;" Step and Step 6 refer to "God;" Step 7 "Him;" Step 12 a spiritual awakening) (Alcoholics Anonymous, 1939, 1976). It is understandable that dropping out of AA has been linked to disliking AA's concepts of powerlessness and higher power (Kingston, Knight, Williams, & Gordon, 2015).

Yet another similarity between CCT and AA is that clients are vulnerable compared to counselors (and leaders or sponsors), who bear a responsibility to be congruent, genuine, and real with clients (members and sponsees). Regarding the importance of genuineness, Rogers (1961, p. 50) says, "I have come to recognize that being trustworthy does not demand I be rigidly consistent but that I be dependably real (Rogers, 1961, p. 50). In AA, realness involves honesty rather than making excuses, blaming others, or denying responsibility for damage caused by drinking (Alcoholics Anonymous, 1939/1976).

The Client Centered Core Conditions in AA

It would be reasonable to expect to see the client-centered core conditions working in AA, considering that substantial research finds the CCT core conditions to correlate with various positive counseling outcomes, and that empathy is especially necessary for all bonafide therapy systems (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; King, Sibbald, Ward, Bower, Lloyd, Gabbay, et al., 2000; Oddli, Nissen-Lie, & Halvorsen, 2016; & Wampold, 2011). However, a chief criticism of AA is that empathy is lacking and members are not free to be themselves, at least not outside the confines of the steps. For AA, the steps provide necessary

structure and members are constantly reminded , "it works if you work it; so work it, you're worth it."

Although AA does not seem to promote empathic understanding or genuineness in the manner seen in CCT, the core condition of Positive Regard, or Acceptance, is highly valued in both CCT and AA. Rogers (1961, p. 17) famously said, "…the curious paradox is that when I accept myself as I am, then I change." The Big Book of AA says, "Love and tolerance of others is our code" (Alcoholics Anonymous, 1976, p. 84). Communications of acceptance are expected to be seen in AA.

Humanistic and Existential Factors

Humanistic (Maslow, 1943) and Existential (Yalom, 1995) factors expected to be seen in AA include the qualities of, Safety, Belonging, Self-Esteem, Cohesion, Interpersonal Learning, Altruism, and Universality. Research overwhelmingly finds that AA's success is due to its providing socialization and support for sober living (Kelly, Raftery, Deane, Baker, Hunt, & Shakeshaft, 2017). The AA environment helps mediate and manage stress without turning to alcohol (Van Der Eijk & Uusitalo, 2016). It offers a safe, supportive place to discuss problems, get feedback, and hear how others cope and overcome difficult situations (Kelly, et. al., 2017). AA discourages connecting with "people, places, and things" that support or grant access to substances and unhealthy relationships (Van Der Eijk & Uusitalo, 2016).

People who highly rate AA appreciate its emotional support and existential values of hope, meaning, and purpose (Kingston, Knight, Williams, & Gordon, 2015). Because people with addictions have a dependent relationship with a substance, their treatment should intersect with family, culture, and social programs like AA (Adams, 2016). Vaillant (2014) notes that, "Alcoholics Anonymous (AA) works because it discovered the use of positive emotions and connection to a group as a therapeutic tool 50 years before academic psychology discovered positive psychology" (p. 214)."

Integrating CCT and AA

To reconcile the fact that many clients with drinking problems have no interest in AA, Miller and Rollnick (1991) developed Motivational Interviewing (MI). The MI approach uses CCT to establish trust and influence, which is then used to direct clients toward recovery outcomes. Many CCT counselors object to using CCT attitudes for ulterior motives; although many integrative approaches treat the CCT conditions as necessary but not sufficient, and use the conditions as a means to an end

rather than an end in themselves, a way of being. Similarly, harm reduction and resistance reduction models (Marlatt, 1996; 1998; Tatarsky, 2002) embrace CCT principles of respecting a client's right to individual decisions and lifestyle choices, while they implicitly strive to reduce use and associated harm by resistance reduction.

There is evidence to support counselors socializing clients to AA values and principles (Kaskatus, 2009; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009). Research shows that motivational encouragement can increase client attendance at meetings and reduce substance use over time (Monico, et al.,2015; Vederhus, Timco, Kristensen, Hjemdahl, & Clausen, 2014). The counselor must have a solid relationship with a client to effect such influence, and client-centered attitudes are very useful for being able to effectively match and tailor AUD treatments to clients (Noar, Benac, & Harris, 2007; Pagano, White, Kelly, Stout, & Tonigan, 2013). A purely client-centered approach offers unconditional acceptance to clients for their unique, individual development (Bryant-Jeffries, 2001; Tarter, Kirisci, Ridenour, & Bogen, 2012).

Method

This research is based on a class assignment by the first author, that introduced counseling students to AA as a stand-alone or adjunct therapy. The assignment required students to participate in an experiential, observational activity wherein they recorded their personal attitudes toward AA, and behaviors observed in AA. Students were instructed on the types of personal reactions and group member behaviors to observe, as seen in the Materials section below. The research was approved by a university Institutional Review Board (IRB).

Participants

Participants were 52 master's degree students in counseling enrolled in a family addictions class taught by the first author from 2012 to 2016. The sample includes students who attended AA, from an original pool of 67 students, 15 of whom attended a group other than AA (e.g., NA, Alanon).

Materials

Students were given an assignment to attend a self-help group. They were encouraged to attend an open meeting unless they were an AA member, and to be truthful if asked why they were there. Members of AA were recommended to attend a group other than their homegroup.

Directions on completing the assignment provided in the class syllabus addressed how to write-up personal reactions and group obser-

vations. "Personal reactions consist of: feelings, thoughts, and behaviors experienced before, during, and after attending the group." Group observations cover: 1) Rogers' (1957) core conditions, 2) Maslow's (1943) humanistic needs, and 3) Yalom's (1995) existential curative group factors. A brief overview of the CCT core conditions, humanistic needs, and existential group behaviors was provided in class, but students were recommended to review these concepts from their prerequisite courses in Fundamentals of Counseling and Group Counseling to complete the assignment.

Procedures

The course instructor printed out the 52 reports and blanked out any identifying information. Reports were mixed up, and numbered one to 52 for easy referencing. Two of the researchers coded all 52 student participants' qualitative statements according to themes established by the assignment (see Materials section above). Disagreements in coding were rare and were resolved through consensus. Graduate assistant Emily Bocci provided coding for the religion variable, and a second coder provided consensus.

Results

Characteristics of the Sample

In order to maintain student and AA member anonymity, students were instructed to not provide demographic data on themselves or group members. Any personal or group member identifier was blanked out of each report. No descriptive data is explored in this study.

Students' Personal Reactions to Attending AA

Anxiety About Attending AA

More than half of the students (54%; n = 28) reported feeling anxious about attending an AA group (see Table 1). Several described the source of their anxiety to be a "fear of intruding." One student wrote, "I was half expecting people to put up walls since I was an outsider in their group with no personal experience with alcoholism in my life."

Stigmas About Alcoholics and AA

Table 1 shows that 42% (n = 22) of students reported holding a stigma about people in AA. One student talked about not wanting to be mistaken for someone with an addiction. Others cited negative assumptions like expecting members to appear "different," "disheveled," or "down-trodden." One student remarked, "You know stigmas are there, but you're

not always aware of it." Relatedly, 25% (n = 13) of students were surprised that AA members appeared normal.

Feeling Welcomed by AA Members

Despite feeling anxious about attending AA, ninety percent of students (90%; n = 47) reported feeling welcomed and accepted by AA group members (see Table 1). One student wrote, "When I walked in, a woman came right up to me and gave me a hug and thanked me for coming." Another said, "the openness and acceptance of the group was the most amazing thing I experienced because I had never met these people before, and they were very welcoming." The vast majority of students experienced the comradery for which AA is known. Only a couple felt uncomfortable with members seeming solicitous in greeting them.

Table 1. Student Participant Personal Reactions to AA (n = 52)

Student Personal Reactions (before, during, and after group)	**n**	**%**
AA Member Accepting/Welcoming of Student	47	90
Feeling of Anxiety with Fear of Intruding	28	54
Stigmas about "Alcoholics/Addicts" and AA	22	42
Surprised that Group Members are "Normal"	13	25
Feels Sympathy toward Group Members	11	21

Students' Observations of AA Group Member Behaviors

Unconditional Positive Regard, Genuineness, and Empathy

Table 2 shows that 52% (n = 27) of the students observed AA members to communicate with unconditional positive regard (UPR), or acceptance. Statements coded for UPR included, "I found it interesting that when someone was talking, no one jumped in or pushed judgment or even tried to say anything when the person was done talking." And, "Everyone was so accepting of her and [yet] no one agreed with her." Also, "They were willing to have those in the room in a position to judge them for what they have done and relying on them to not judge them for their past problems." In Table 3, significant phi correlations are seen between UPR and

powerlessness ($\Phi = .30$; $p = .026$), UPR and existential themes ($\Phi = .284$ $p = .041$) and UPR and "would refer to AA" ($\Phi = -.443$; $p = .001$).

Genuineness was defined by student statements that pertained to freedom to think open-mindedly, letting variant ideas be brought into awareness, e.g., doubting the steps or denying the alcoholic identity. Based on our definition, only two genuineness behaviors were observed! When members veer from the alcoholic narrative, they are supported to continue to work the program. Likewise, communications of empathy, defined as using reflective statements of meaning or feeling, were also very uncommon.

Belongingness/Cohesion

Most students (85%; $n = 44$) witnessed behaviors that we coded as Belonging/Cohesion (see Table 2). These behaviors expressed that members were a part of something, and included clapping, and statements like, "thanks for sharing," and "keep coming back" (see Table 2). Belongingness/cohesion statements included, "These people had formed a bond together and had been coming to this particular meeting for a while." "They discussed the social that they were having in a couple weeks for the group." "There was a feeling of calm and camaraderie among the members and I immediately felt at ease being an observer." "The next gentlemen went on to explain how AA is the only place that made him feel comfortable," and, "There was… a family like atmosphere within the group." One student wrote, "The most important aspect that a member could ever gain from attending AA meetings is they are not alone."

Universality

The curative group factor of universality (Yalom, 1995) was reported by 77% ($n = 41$) of students. Universality was coded when comments referenced alcoholic/addict and recovery identities, as in member statements like, "I know everyone doesn't like me, but they will respect me because I have what we all have in common, and that is being addicts." And, "They told everyone in the room that we all are addicts here and the natural thing for us to be doing is using." Universality encompasses alcoholic/addict symptoms of holding onto resentments, blaming others, having difficulty loving others toward whom anger is felt, and "hatred and anger eating one alive." Universality encompasses recovery identity, rebirth, and how the big book saved lives, marriages, and jobs.

Existential Needs, Powerlessness, and Religious Symbolism

Table 2 shows that nearly three-fourths of the students (73%, *n* = 38) reported that AA members talked about Existential Factors. They talked about the AA program giving them meaning, purpose, hope, and the ability to have a positive view of themselves. Nearly two-thirds 63% (*n* = 33) of the sample reported that members discussed Powerlessness over their use (see Table 2), and two thirds (67%; n = 35) recorded religious symbolism and language (e.g., the serenity prayer, using the word God). Also, two-thirds of students reported that AA members showed Altruism in the form of Imparting Information (67%, *n* = 35). For instance, one student wrote, "I was surprised by how accepting and friendly these members were and how they explained different things about the program to me without me having to ask." Another said, "It was …an eye opener for me to be exposed to a group of people who were so welcoming and open to explaining their alcoholism," and, "They all were so welcoming and warm to the idea of helping me understand their perspectives." Table 3 shows a relationship between AA Member Altruism/Imparting Information and Student Sympathy (Φ = -.342; *p* = .014).

Table 2. Observed AA Group Member Behaviors (n = 52)

AA Group Member Behaviors	**%**	**n**
Belongingness/Cohesiveness (includes "thank-you for sharing," "keep coming back," and clapping)	85	44
Universality (relatable situations, AUD and life problems and efforts to work the program)	77	41
Existential Factors (meaning of life, purpose, hope, chips)	73	38
Altruism via Imparting Information	67	35
Religious Symbolism or Language	67	35
Powerlessness over Alcohol/Substance	63	33
Positive Regard, Members are Non-Judgmental	52	27
Life Became Unmanageable	40	21

Table 3 presents phi (Φ) correlation coefficients of significance for the dichotomous variables measured. High significance emerged between holding a stigma and surprise that members appear normal (Φ = .584; p = .000), and holding a stigma and noticing group members talk about their life as unmanageable (Φ = .401; p = .003) (see Table 3). These correlations are significant, but the direction of the relationship is unknown.

Table 3. Statistically Significant Φ Coefficients (Correlations) between Dichotomous Behaviors [Observed or Not Observed] (n = 52)

Correlated Factors	Φ	Sig
Stigma w Surprised Normal	.584	.000
Stigma w Unmanageable	.406	.003
Fear of Intruding w Group Acceptance	.352	.011
Belonging-Cohesion w Universality	.511	.001
Belonging-Cohesion w Existential	.387	.020
Universality w Existential	.323	.020
Universality w Religious Content	.342	.014
Positive Regard w Would Refer to AA	-.443	.001
Positive Regard w Powerlessness	.309	.026
Positive Regard w Existential	.284	.041
Powerlessness w Student Sympathy	.295	.033
Powerlessness w Student Group Learning	.272	.050
Altruism-Impart Info w Student Sympathy	-.342	.014
Student Group Learning w Student Sympathy	.268	.053

Observations of Positive Regard correlated with observed Powerlessness (Φ = .301; p = .026) and Existential Needs (Φ = .284; p = .041). In other words, Positive Regard was expressed conditionally, i.e., when members express conformity with ideas in Step 1, "We admitted we were powerless over alcohol and that our lives had become unmanageable," and Step 2, "Came to believe that a power greater than ourselves could restore us to sanity."

Discussion

The present study found that assigning students to observe an AA group gave them a context for developing self-awareness of personal stigmas and anxieties about AA. The assignment provided students with an occasion to be welcomed by AA members, who showed altruism and imparted information to the students. m. It required them to refresh their knowledge of the CCT core conditions and therapeutic group counseling behaviors, and allowed them to see potential benefits and limitations of AA.

Students did not observe empathic and genuine communication in AA groups, as expressed in the CCT tradition. This is not surprising considering that AA is seen to be an inadequate substitute for personal counseling. AA is not uncommonly criticized for disallowing self-exploration and openness to feelings and thoughts outside of the 12 step program. That said, according to the high sobriety rates reported by AA, a lack of empathy may actually help insure AA program integrity, such as nurturing the idea that, "there is no problem that drinking can't make worse," And "It works if you work it, so work it, you're worth it."

Eighty-five percent (85%) of the students noticed that AA groups satisfied Belongingness and Cohesion needs of its members. In addition, 77% of students said that AA groups expressed Universality through shared experiences of alcoholic and recovery identity, and powerlessness. Counseling students reported that Positive regard played a significant role in communications among members. Positive regard was seen to correlate with powerlessness and unmanageability.

According to Rogers' (1951) proposition # 6, "the organism has but one basic tendency and striving, which is to actualize, maintain, and enhance the experiencing organism." From the AA perspective, the disease of addiction inherently cultivates a false identity. The person with an addiction is demoralized, and requires support, love, encouragement, redirection, and perhaps an awakening of spirit or a leap of faith. They must admit they are powerless. Drinking, from the perspective of AA, inhibits growth of the true self, an iatrogenic effect of self medicating. This model is theoretically comparable to defensive thwarting of self-actualization in CCT, humanism, and existentialism.

The notion that defenses thwart self-actualization is shared by all of the approaches explored in this study; although each approach views the source of defenses somewhat differently. In CCT, defenses point to conditions of worth. In humanism, defenses signal threats to safety, belonging, love, self-esteem, etc.. Existentialism views defenses as protection against fear, isolation, loss of meaning, value, purpose, and hope.

In contrast, AA considers defenses to be symptomatic of the disease of addiction.

Counselors of all orientations who understand the strengths and limitations of AA will be better equipped to refer clients knowing what AA has to offer. Due to its success, regulatory bodies recommend AA in clinical treatment protocols. This includes the Association for Specialists in Addiction Medicine (ASAM), which sees participation in AA to augment medically assisted treatment (ASAM, 2016). Also, the Substance Abuse and Mental Health Services Administration (SAMHSA), which Mental Health Insurance payers use to regulate reimbursement in Medicare and Medicaid, supports referrals to AA. According to the vast majority of students, AA members were overwhelmingly welcoming and eager to help them understand what AA has to offer. With preparation of students to visit ethically, a visit to AA can be a valuable resource for students to learn about group member identity development.

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[i] See, for example, Afifi, Felix, and Afifi (2011); Bromet et al. (2017); Foa, Stein, and McFarlane (2006); Goldmann and Galea (2014); Kõlves, Kõlves, and De Leo (2012); Maclean, Popovici, and French (2016); Schwartz, Liu, Lieberman-Cribbin, and Taioli (2017); and Vitaliano, Maiuro, Bolton, and Armsden (1987).

[ii] See, for example, Espinel, Galea, Kossin, Caban-Aleman, and Shultz (2019); Espinel, Kossin, Galea, Richardson, and Shultz (2019); Hayes, Blashki, Wiseman, Burke, and Reifels (2018); O'Donnell and Forbes (2016); and Shultz, Kossin, and Galea (2018).

[iii] For example, those who practice emotion-focused therapy, (EFT; e.g., Greenberg, Rice, & Elliot, 1993; Timulak and Pascual-Leone, 2014–see Elliot, 2011, for discussion on EFT as a person-centered derivative).