INTRODUCTION

I have previously written about family-centered therapy (Gaylin, 1989, 1990, 1993), an approach which views interpersonal dynamics as central to the psychology of the individual and, therefore, also to therapeutic change. However, neither individual client-centered nor family-centered therapy has yet explored the developmental process of self-actualization. That is, the emergence and development of the self in its natural context, the family, both underlies and parallels the evolutionary process that culminates in self-actualizing. The issues of a family-actualizing process (Gaylin, 1990) and a family shaped self need to be carefully addressed so that we may better understand the fully functioning person and the human condition.

Carl Rogers began his career as a child therapist (Rogers, 1939). He was also one of the first therapists or theorists to emphasize the basic caring nature of the therapeutic relationship and its restorative powers (Rogers, 1942, 1957, 1961). Yet, Rogers's writings barely touched upon the significance of the family-based relationships from which the self evolves.

This inattention has hindered the expansion and application of client-centered theory into a more comprehensive approach to the human condition. The intention of the most recent change in nomenclature from "client-centered" to "person-centered" theory was to extend Rogers's methods beyond psychotherapy into all arenas of human interaction (e.g., education, peace initiatives). However, simultaneously the term "person-centered" underscores what I consider to be a lingering flaw in Rogerian theory – namely the idea that individuals are inherently independent (Rogers, 1942, pp. 72-73; 216; 227). Thus, such a nomenclatural change has deflected us from our understanding that the human condition is defined by our mutual interdependence, and our recognition that this intimate interconnectedness is the hallmark of the fully functioning person. On the other hand, consideration of person-centered relationships in developmental context facilitates a more thorough understanding of a key concept in person-centered theory – that of self-actualization, or simply, "becoming a person."

BASIC CONCEPTS

Basic to person-centered theory are the concepts of the self and its actualization. Thus, traditionally, Rogerian self psychology has easily been cast as a psychology of the individual, although it should really be viewed as a psychology of humanness and of people in relationship to one another. Further, any self psychology should define and examine the developing self in the context of others. Therefore, the person-centered approach to self psychology needs to be reconsidered with the central position of the interpersonal elements in the development of the person underscored.
The Actualizing Tendency and Self-Actualization

Often our understanding is blurred regarding two key concepts of the person-centered approach: the actualizing tendency of the organism and the self-actualization of the individual. Goldstein, when he introduced the terms (1939, 1940), tended to use them interchangeably. Later (1959) Rogers appropriately distinguished between them, noting that the actualizing tendency is the innate press in all organisms – from plankton and amoeba to sequoia and homo-sapiens – to fulfill their biological destiny. For the human organism the actualizing tendency gives birth to a very special feature, the self system, from which the uniquely human process of self-actualization derives. According to Rogers, early on, (although he does not specify exactly when),

. . .a portion of the individual's experience becomes differentiated and symbolized in an awareness of being, awareness of functioning. Such awareness may be described as self-experience . . . This representation in awareness of being and functioning, becomes elaborated through interactions with the environment, particularly the environment composed of significant others into a concept of self, a perceptual object in his experiential field [emphasis added], (1959, p. 223).

Self, Role, Subself, and Self-Complex

Self recognition, the ability to perceive one's own entity as distinct from other entities, is primarily a human characteristic, although it has been observed in a few infrahuman animals (see Gallup, 1970). Self awareness, the ability to distinguish ourselves as both actors and objects of actions, is a more complex and sophisticated concept, and to our knowledge is an attribute solely of humankind. In 1890, William James introduced a new conceptualization of the self to the behavioral sciences. James discerned many selves within the person. His elaboration of the "stream of consciousness" and his complex exegesis of the "hierarchy of selves" were central to James's understanding of the human condition.

James's brilliant conceptualizations of consciousness and self awareness were, however, eclipsed by Freud's delineation (1900) of the subconscious and the tripartite (id, ego, and superego) functions of the human psyche as a schematic for understanding all human behavior. Later, nearly half a century after James presented his theory, George Herbert Mead (1934) borrowing heavily from James, reintroduced the concept of the self to the social sciences. Mead, like James (1890), distinguished two primary aspects of the self: the "I," the subject of actions, and the "me," the object of actions. Mead also crystallized the idea of the centrality and the multifaceted and interpersonal nature of the self and its components.

In the first half of the twentieth century, however, the battle between the concepts of "ego" and "self" was no contest in the therapeutic community. Freud's ego had won, and psychodynamic psychiatry dominated thinking in psychotherapy. As late as 1953, Harry Stack Sullivan attempted to introduce self psychology to the psychiatric community via his theory of interpersonal psychiatry and human development, but, despite his efforts, the tripartite function of the psyche, with the ego as controller, retained its hold in medical psychiatry and had a virtual monopoly on the practice of psychotherapy.

Nonetheless, in academic psychology, the battle continued (see Koffka, 1935; Allport, 1943 and 1955; Chien, 1944; Bertocci 1945; Sherif & Cantril, 1947; and Symonds, 1951). It was Rogers, first in 1942, later in 1951, but most persuasively in 1959 and 1961, who integrated the concept of the self into psychotherapeutic practice, made it fundamental to a theory of personality, and, in the process, changed the face of psychotherapy.
At roughly the same time that Mead (1934) proposed his theory of the self, Bateson (1936) introduced the concept of social role to the behavioral sciences, and role theory was embraced. Today, unfortunately, social role is often used interchangeably with, or as a substitute for, the concept of self, resulting in a merging of the two ideas; thus, doing a disservice to both. The concept of role and role playing, elaborated by Bateson in 1936 (and later, with Reusch, 1951) is far different from the theory of a multiplicity of selves posited by James and Mead.

According to Bateson, role is a sociological concept defined as a set of expected behaviors attendant to a particular status. As the word itself implies, a role is a kind of mantle offered by the culture and donned by the individual. The mantle alternatively may be taken on and correspondingly let go, just as an actor assumes a role in a play.

Yet the array of roles which society recognizes, defines, and ascribes is dramatically different from the many selves which each of us as individuals identifies experientially from within and continuously integrates into our being. Each of our selves and our judgments concerning them constitute an amalgam of self that gives rise to our attitudes, judgments, and feelings about who we are. Reciprocally, these thoughts about ourselves shape the ever evolving amalgamated self.

Attempting to understand the process of change in both individual and family psychotherapy requires closer scrutiny of the distinction between the concepts of role and self. Mead's (1934, p. xxi) discussion of the concept of role focused on "role-taking," and clearly delineated a process not unlike empathy, whereby one person perceives and, to some degree, is able to take the part of another. Today, the word role is often used loosely to designate either: (a) an outward aspect of the person, a position or function which we fulfill; or, (b) a part of the self, i.e., the entire experience of being a child, student, parent, worker, etc. Yet, the latter experiences and the identities they create for us should not be regarded as roles that are simply assumed by the individual, or ascribed by the culture as a means of identifying a person's job within a societal context. Rather, these identities originate within us as we interact with our environments and they become an integral part of the way we think of ourselves. Therefore, these identities may be more accurately termed subselves, the amalgam of which may be termed the self-complex.²

Working from within an amalgamated self-complex, we develop a sense of worth or self-esteem which is grounded in our overall sense of adequacy, sufficiency, or competence. This evaluation comes from our recognition and assessment of self, and is who we believe we are. It is pain laden self-evaluation resulting in an attenuation of self-worth or self-esteem, not simply role confusion, which causes people, (individuals and families) to seek relief from their anguish through psychotherapy.

Self-Esteem

Perhaps no other construct in psychological theory has received more attention in the past generation than that of self-esteem. Self-esteem is a term bandied about by the general public more than it is discussed in the literature of the behavioral sciences. Poor self-esteem is considered to be the cause of virtually every intra and interpersonal individual problem from children's poor school achievement to adult sociopathy (Coopersmith, 1967). Although not identical to Rogers's concept of incongruence it is related to it (see below).

Self-esteem was first empirically defined by William James (1890, p. 310) via the following mathematical formula:

\[
\text{Self-esteem} = \frac{\text{Success}}{\text{Pretensions}}
\]
The formula denotes that our perceptions of our accomplishments ("Success" in the numerator), weighed against our aspirations ("Pretensions" in the denominator) determine our feelings of self-worth. More simply put, the more we believe that our successes measure up to our expectations for ourselves, the better we feel about ourselves. About this equation, James (1905, p. 187) notes that:

Such a fraction may be increased as well by diminishing the denominator as by increasing the numerator. To give up pretensions is as blessed a relief as to get them gratified; and where disappointment is incessant and the struggle unending, this is what men will always do.

In other words, recognizing the unrealistically high standards we have, at times, set for ourselves and subsequently lowering them can effectively have the same impact on our feelings of self-worth as meeting high standards.³

Each of our many subselves contributes to our overall sense of self-esteem or self doubt. An intricate, delicate, and unique interaction is created by our own evaluation and derived sense of competency regarding each of these subselves and the self-complex as a whole. Furthermore, maintaining integrity and balance within the self-complex defines our sense of psychological well being at any moment in time. If, for example, either as a life's goal, or during any given period, a person strives to be a good parent, that person may simultaneously care less about being a successful worker, or vice-versa. Thus, for the individual at that juncture, the less emphasized subselves would carry less weight in the computation of self-esteem of the total self-complex.

It must be stressed that although our aspirations may be shaped by our culture and social milieu, it is the individual who continuously defines the intricate equation of self-esteem. Therefore, depending upon subtleties of biological state, context, mood, etc., the numerator and/or the denominator in the formula may change, either subtly over time, or abruptly. At different times, depending on our sense of purpose and aspiration, we may invest differently in each of our subselves, giving more weight to one than the others.

Since each of our many subselves may be the focus of our attention and energy at any point in time, the self-complex is always in a fluid state, continuously amending and reintegrating itself. Thus, one cannot simply average the sum of the various evaluations of the many subselves and the perceptions of their adequacy or inadequacy to get a single measure of self-esteem for a given individual. This ongoing and, perhaps, constantly changing evaluation is uniquely ascertainable only by each person. And when the result of that evaluation causes anguish, which the individual or the family cannot relieve despite their most valiant efforts, it is then that they may be impelled to seek psychotherapy.

Thus, the self and self-evaluation are central to our understanding of psychological well being, the fully functioning person, and the therapeutic enterprise. It is this recognition of centrality of the self that has led to what Seeman (1988) refers to as "the rediscovery of the self in American psychology," during the last quarter of a century (see especially Neisser, 1993).

DEVELOPMENTAL ISSUES

The Beginnings of the Self

It is difficult to talk about people, particularly the individual, without referring to the word self. As a consequence there is a tendency to get caught up in tautologies when discussing how the self develops. Etymologically, the word self is so basic to our communication that it is impossible to determine when the word was introduced into our language. Appropriately, the Oxford English Dictionary (1971) starts by defining the word self as, "the primary sense."
It is naturally assumed that one's experience of bodily self is mandatory, precedes, and leads to an awareness of oneself as a being separate from all others. Infants in the first few months of life may be seen engaged and absorbed in explorations of their bodies. These explorations are further assumed to be precursors to the development of our young ones' notions of first the "me" (the empirical) and then the "I" (the knowing) aspects of self.

The developmental progression continues. According to traditional thinking, the transition from self awareness to a sense of separateness of being follows the offspring's awareness of its position and place in the family. With such recognition, the youngster's knowledge of self, as a being distinguished from others, becomes a reality. Until recently, this distinction was thought to occur at about the age of three to four years, when toddlerhood ends and the preschool years begin. It is during this period that developmental theorists (e.g., Erikson, 1950; Piaget, 1951; Mahler, Pine, & Bergman, 1975; Werner, 1957) have maintained that children begin to distinguish in meaningful ways between self and significant others in the environment. The late toddler/early preschooler actively takes the part of others, first through mimicry, and then through language and games. Such behavior implies the concomitant development of empathy and social interaction.

However, more recent evidence (Sagi & Hoffman, 1976) suggests that this process of differentiation and imitation begins far earlier in life: Despite a relatively limited range of socio-emotional responses (i.e., contentment versus distress), human neonates display a predisposition to empathy and interaction from birth. Furthermore, rather than the previously assumed long period of self-centeredness thought to be characteristic of the very young, recent investigators' observations note the beginnings of an interpersonal empathic process by as early as the first birthday (Brunner, 1986). Thus, although there is presently no way of discerning whether or not the self is innate in the human organism (Mead, 1934; Zimring, 1988), there is little question that we are biologically primed to be socially interactive from birth, if not before (Condon & Sander, 1974; Meltzoff & Moore, 1977). The natural conclusion is that the propensity for self definition through interaction with others is, indeed, somehow inherent in the human organism.

**Maturation and the Development of the Self-Complex**

We first become aware of ourselves bodily, through general experiences: feelings of distress, (e.g., hunger, cold) and correspondingly relief and comfort (e.g., satiety, warmth). Soon thereafter we begin to experience ourselves as beings with physical parts (e.g., vocal cords, mouth, fingers, toes). Thus, our earliest self awareness develops. But it is in relation to others that we define ourselves as a person other than just a being (Gibson, 1993). It is the difference between our awareness of being and our recognition of ourselves as interactive people that distinguishes the actualizing tendency (the biologic) from the self-actualizing tendency (the psychosocial). It is this distinction which makes us sentient and uniquely human, and which creates uniquely human joy and anguish in evaluating the quality of our lives.

From the earliest body awareness of ourselves, we begin to experience and subsequently recognize our subselves through our interactions as dependent children in relation to primary care-giver(s), generally, our parent(s) (Trevathan, 1993). Gradually, we also become aware of other significant persons in our life space. Through our relationships with them, we continue to identify various subselves. Thus, the personal and experientially derived conceptualization of our subselves as brother or sister are usually formed early within the family environment. These selves derive from the very beginnings of children's experience and conceptualization of themselves if they are not first-born. On the other hand, first-born children develop these selves later when presented with succeeding siblings. When we are interacting with our siblings, we act, indeed, out of an awareness of our own sibling subselves in relation to them. With a grandparent,
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aunt, or uncle, we establish relationships which we and they reinforce with each new encounter, thereby defining new subselves. Thus, we approach each interaction from the relational positions which we have assimilated into our set of subselves, i.e., the self-complex.

Although many of these inter-familial subselves are formed very early in life, usually within the first two years, many other subselves continue to evolve throughout our life span development. As social, physical and intellectual maturation continue, the subselves of playmate, friend, neighbor, student, etc., also become parts of the self-complex, typically in the preschool years (i.e., three to four years of age). Beginning with puberty and the onset of physical maturation, the subselves of lover, spouse, worker, parent, and grandparent, are gradually added, via new experiences, to the repertoire of perceived and identified subselves. Thus, we self-actualize. As we mature, incorporating new subselves augments and enriches the self-complex; we relate to larger interpersonal networks in more complex ways, with each increment fleshing out the continuum of self-growth and redefinition of previous experiences and definitions of the self-complex (see Neissen, 1993).

We can never divest ourselves of the interactionally derived subselves of our self-complex even though the principals may die. Death may end active interpersonal exchange with a person, but it does not terminate the relationship because each relationally created subself lives on within us. In our minds we remain the child of our parents, even after their death. We are forever child to our parent, brother or sister to our sibling, etc. even though, under grievous conditions some might wish to divest themselves of these subselves. With specific reference to a perceived egregious and therefore unwanted subself, such dissonance may in fact be reason to drive an individual or family to seek relief through psychotherapy.

It should be noted that these formulations of self, while employing some of the same appellations as those delineated by societally ascribed roles, are, nonetheless, substantively different from them. These experiential, relationally defined entities are not, like roles, exogenous to our being: Rather, they are indigenous subselves, which become integral, though not always integrated, parts of our self-complex forever. Even when we assume various exogenous roles (i.e., student, friend, worker, spouse) on a trial basis, the minutes, hours, or years operating from that perspective serve as a subself which automatically is incorporated into the self-complex. Thus, some of these roles we may proceed to transform into additional and meaningful subselves. Furthermore, depending on our evaluation of whether or not our self-worth rests on the degree to which our aspirations match our successes in these roles, and whether or not we wish these to be meaningful aspects of our lives, we may also cast off these exogenous roles. Nonetheless, even those that are rejected by us contribute to our conceptualized complete self, by helping us to distinguish who we are not from who we are.

It was out of a need to understand such an evolution of psychological growth, that theorists like Freud (1900), Sullivan (1953), Erikson (1959), and Havighurst (1971) developed theories regarding how individuals relate and adapt to their interpersonal environments throughout the life span. It is this development of the self-complex that is the crucial and virtually overlooked aspect of the self-actualizing process in person-centered theory and practice.

IMPLICATIONS FOR INDIVIDUAL AND FAMILY THERAPY

Because of the paucity of information in person-centered theory regarding the development of the self, there is little explanation of how the development of the self figures in or plays out in psychotherapy. Yet Rogers considered not only the importance of the family and interpersonal relationships in the self-actualizing process, but the applicability, as well, of his theory to family life (see Rogers, 1953; and Rogers, 1959, p 241). He noted the importance of the parent-child interaction, particularly the parents' "unconditional positive regard," for their child in creating
"conditions of worth," which, in turn, enable the individual to live with a "continuing organismic valuing process." However, rather than integral, these considerations appeared to be after-thoughts or footnotes to his theoretical formulations regarding human functioning and the psychotherapy process.

Ideas regarding the self and the context in which it develops are intimately connected with those elements of the therapeutic process that Rogers (1957) deemed psychologically restorative (i.e., "the necessary and sufficient conditions for personality change"). Understanding not only the development of the self but the manner in which people's self-complexes interact during the therapeutic process can have extensive ramifications for the manner in which we think about, perform, and evaluate psychotherapy.

**Individual and Family Incongruences**

According to Rogers (1959, p. 203) one of the main reasons an individual seeks psychotherapeutic help is because the person is experiencing feelings of incongruence. Incongruence is a discrepancy between the actual experience of the individual and the individual's image of self. The reasons for the discrepancy may or may not be known by the individual. Incongruence may be mild, causing anxiety and/or other general psychological discomfort. When severe, however, incongruence invariably causes incapacitating anguish.

Comprehending the interaction among the subselves of our self-complex is crucial to extending our understanding of both our intra and interpersonal dynamics, particularly with regard to self-esteem and Rogers's focal concept of intrapersonal congruence and incongruence. For example, feelings of worth regarding one or more of our various subselves could compensate for feelings of inadequacy or failure in other subselves.

Incongruence, often accompanied with feelings of anxiety and/or despair, may occur when: (a) a particular subself is so dominant that feelings of inadequacy regarding that subself contaminate our feelings of self-worth regarding all of our subselves, or (b) when virtually all subselves within the self-complex are sensed to be lacking or inadequate. Either of these conditions can lead to incongruence which, in turn, may move the individual to seek psychotherapy. In a similar fashion, a family may seek therapy when any one if its members displays, through dysfunctional behavior, such incongruence, or when the system as a whole experiences incongruence (see Gaylin, 1989, a 1990).

**The Presentation of Self in Individual and Family Therapy**

One might suppose that clients would begin therapy by presenting the most pressing aspects of their incongruence, that is, those causing the most pain and debilitation. There is, however, evidence (Rennie, 1990) which suggests that it is far more likely that clients ease into the therapeutic process, presenting a generalized state of anxiety, editing the presentation of the self-complex to the therapist. Thus, knowingly or unknowingly, clients may hold back some of the more painful aspects of their self-incongruence, depending upon their perceptions of and initial experience with the therapist, and their degree of trust of the therapeutic relationship (Frank, 1961).

Such differing entrances into therapy are natural in individual client-centered therapy, wherein the client is more or less in control of the initiation, direction, and pace of the therapy session and the general course of therapy. Accordingly, a client may talk initially about his or her difficulties as a parent, and defer disclosure of felt inadequacies as a mate or lover, perhaps until the client feels less vulnerable and less at risk within the therapeutic relationship. Thus, although individual clients may seem to be experiencing incongruence surrounding either a particular subself aspect of the self-complex or a generalized sense of incongruence of the total self-com-
plex, the therapist, invariably, will not immediately be aware of the full scope of the presenting problem. This lack of connotation may result from the client's own lack of awareness, the client's editing, the therapist's incongruence or inadequate empathy for the client, or some combination of all.

In the context of family-centered therapy, each family member brings to the session his or her individual incongruence along with those contributed to and by the entire family system (see Gaylin, 1989, 1990). The incongruence experienced solo by each family member also may be, intentionally or unintentionally, thrust upon any or all family member(s), thereby exposing or even creating additional individual and familial incongruence. These process intricacies within the family session represents a critical and functional distinction between individual client-centered and family-centered therapy. In the latter, for example, a husband or wife may be forced to face the incongruences surrounding his or her spousal subselves as a result of the data (perceptions, experiences, etc.) presented by the mate in their joint therapy session. Similarly, in multiple generation family therapy, parents may find themselves forced to confront an inadequacy of their parental subselves upon hearing their child's experience of them as parents. This inadequacy may have been sensed by the parent but never openly dealt with, or, on the other hand, it may have been totally unidentified or denied by the parent because of the parent's lack of awareness or comprehension. The situation here can become even more complex when one family member is confronted with another family member's perception that the first member exhibits subself incongruence when that member appears not to have sensed this disparity from within.

Process Similarities and Differences in Individual and Family Therapy

Although distinct process differences between individual and family-centered therapy may not appear to require a sea change in the therapist's orientation and modus operandi, the complexity of the therapist's task is exponentially extended in the family therapy session. As has been demonstrated elsewhere (see Gaylin, 1989 and 1990), the stance of the family-centered therapist is little different from that of the individual client-centered therapist. Empathic reflection is the primary behavior of the therapist within both situations. However, the dynamics of family-centered therapy demand that the family-centered therapist be in tune with the frames of reference of every family member, and simultaneously maintain an empathic position with each.

Indeed, family-centered therapists listen in a somewhat different fashion from their individual client-centered therapist counterparts. The therapist must hear and empathically process what each family member is saying not only from that member and the therapist's own vantage-points, but from the vantage-point of each of the various other family members as well. Thus, the therapist must shuttle back and forth among the frames of reference of all family members as the therapist both listens and empathically reflects. The family therapist must be ready and able to be empathic with the potential impact of any family member's verbal or nonverbal expressions on all of the other family members, each of whom is present with his or her own functional or dysfunctional self-complex.

The family-centered therapist must also verbally reflect the "interspace" (Gaylin, 1990) between various family members. Interspace reflections are made when there is an interpersonal incongruence - a conflict between the experiences and perceptions of two or more views and experiences of a given situation. This new kind of reflecting behavior, emphasized in the family-centered therapist's behavioral repertoire, may have potential for application to individual therapy as well. The suggestion is that there is an analogue between the potential intrapersonal incongruence among the subselves of an individual, and the incongruences which occur between and among family members. Although this awareness may not, on the surface, appear to affect the manner in which individual therapists conduct themselves, such an awareness creates a heightened sensitivity to the individual client's struggle, and correspondingly, an increased
capacity for empathic understanding of the complexity of the internal dialogues among a given individual's subselves.

Finally, there are some interesting dynamics within the family therapy session which bridge intrapersonal and interpersonal dimensions. Thus, as the process unfolds in the family therapy session a parent may empathize with his or her child — even identify with the child's expressed anguish, perhaps relating it to similarly stressful incidents in the parent's own childhood experience. Within the family therapy session this empathy may play out openly as a mutually therapeutic engagement between the child and the parent and even extend itself to other if not all of the family members, thereby changing the entire family dynamic.

However, an alternate and more subtle possibility exists, where the effect of interpersonal therapeutic interaction between or among family members on intrapersonal dynamics may be neither openly expressed nor apparent. This can happen when, under certain circumstances and for various reasons, a family member (or members) may have an investment in a given self stance or position. For example, the "stoic, responsible father," might feel the need to maintain a certain degree of opacity, despite his resonance to the pain that his child has expressed in the therapy hour (Stein and Markus, 1994; Straumann, 1994). The vicarious empathic healing of the father while observing and processing the interaction between the therapist and the child (or between/among other family members) may not be able to be shared openly at the time with those present. But this does not alter its impact: On many levels the unblocking of the self-actualizing process and the reassessment of self-worth is occurring through both intra and interpersonal means.

Some Evidence from Research

There is not a great deal of research on the process of individual psychotherapy. Process research in family therapy, by dint of the number and complexity of the interpersonal interactions, is correspondingly even rarer. One of the few research measures which held promise in evaluating individual client process in the therapy session was that of Rice and Wagstaff (1967) on client vocal quality. This measure, which identified four typical client vocal patterns within the therapy session, allowed the investigators to discern one pattern, "focused," to be indicative of therapeutic activity leading to change. Focused vocal quality was found to be highly associated with success in individual psychotherapy. Described by Rice and Gaylin (1973) as a sense in the vocal patterning that the client's "eyeballs are turned inward," the pattern might be seen as that of an inner conversation among the subselves, which has the potential for knitting up an otherwise unravelling self-complex.

In an effort to determine whether or not a similar process indicator could be discerned within the family therapy session, Kilcarr (1987) evaluated the vocal quality of family members during several families' therapy sessions. He found a dearth of focused voice quality in family therapy sessions, even in those cases deemed successful. These findings suggest that the family therapy process is somehow different from that of the individual therapy. Upon reflection, there is an obviousness to this observation. The family therapy session is outwardly less devoted to inner exploration than to the interactions among the family members. Although, it is certain that complex intrapersonal processes are simultaneously taking place, the family-centered arena, though intimate, is still a more public forum than that of individual therapy. However, as previously noted (Rennie, 1990), much goes on within clients to which the therapist is not privy.

Employing measures similar to those of Rice and Wagstaff (1967), Johnson and Greenberg (1988) identified a more interactive vocal quality in marital therapy that holds promise for identifying therapeutic change. They called this vocal quality "softening," which they believed was indicative of a greater "accessibility and responsiveness" (i.e., empathy) between the marital
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partners. Thus, there are indications from research that one of the major healing forces within the interpersonal milieu is the process enabled by the self-complex whereby the many subselves of one person empathically interacts with those of another.

SUMMARY

The person-centered approach is heavily grounded in the understanding of how the self operates both intrapersonally and interpersonally. Although the person-centered approach has extensively explored methods of therapeutic intervention, there is a paucity of material on the understanding of either the manner or the intimate, interpersonal context in which the self evolves. It is contended that these developmental and contextual issues are central to a more efficacious therapy for both individuals and families and, perhaps, more importantly, to our understanding of the basic and indigenous interdependent nature of the human condition.

Key to the person-centered philosophy is the actualizing tendency of all organisms. Growing evidence suggests that we are biologically programmed to be socially interactive. This propensity for self definition through interaction with others gives rise to the uniquely human process of self-actualization, which in that process defines the self system or self complex.

The self system is composed of experientially developed subselves. These subselves and our judgments about them define who we are and how we feel about ourselves. Understanding not only the development of the self but the manner in which people's self-complexes interact during the therapeutic process can have significant ramifications regarding how we think about, perform, and evaluate psychotherapy.

Person-centered theory holds that people seek psychotherapeutic help principally to resolve feelings of incongruence – the discrepancy between self-experience and self-image. Therefore, knowing more about the interaction among the subselves of our self-complex may broaden our understanding of both our intra and interpersonal dynamics. Incongruence, almost invariably accompanied by emotional distress occurs when: (a) a particular subself is so dominant that feelings of inadequacy regarding that subself contaminate our feelings of self-worth regarding all of our subselves, or (b) when virtually all subselves within the self-complex are sensed to be lacking or inadequate.

Just as incongruent individuals seek therapy, so do families, typically, when any one of their members displays incongruence (generally through dysfunctional behavior), or when the system as a whole experiences incongruence. The approach of the family-centered therapist is little different from that of the individual client-centered therapist. Empathic reflection remains the primary conduct of the therapist in both situations; the family-centered therapist maintains an empathic position with each family member.

Despite the similarities, however, the therapist's behavioral repertoire is enlarged somewhat during the family-centered-therapy session. For example, interspace reflections are made when there is an interpersonal incongruence – a conflict between the experiences and perceptions of two or more views and experiences of a given situation. This new kind of reflecting behavior has application to individual therapy in that it heightens the therapist's sensitivity to the possible incongruities among the subselves of an individual client's self-complex. Thus, the theory and practice of person-centered family therapy offer promise for greater understanding of people, both individually and in concert.

REFERENCES

The Self, the Family, and Psychotherapy


FOOTNOTES

1 I would like to thank Art Bohart and Peggy Natiello for their thorough and incisive editorial comments on this paper, and the generosity and graciousness with which they expressed them.

2 Perhaps no one individual has had more to do with incorporating the concept of role into both the theory and practice of psychotherapy than J. L. Moreno (1946). Ironically, his exposition of the practice of psychodrama and its unique techniques have tended to obscure his brilliant theoretical exposition of the concept of role in the development of the individual. Furthermore, the corpus of his work tends to lend credence to the metaphor of role as "mantle," (see Fox, 1987), and thus supports my choice of the term subself over that of role.

3 It should be noted that James's formula for self esteem is essentially that employed by Butler and Haigh (1954). Their adaptation of Stephenson's (1953) technique in the development of a measure of self-esteem, the Self-Ideal Q-Sort, proved to be one of the most productive empirical measures of psychotherapy outcome.

4 Rogers asserts that there exists an inverse relationship between the concepts of incongruence and self-acceptance. He goes even further by noting that the successful client "not only accepts himself – a phrase which may carry the connotation of a grudging and reluctant acceptance of the inevitable – he actually comes to like himself," (1961, p. 87). Thus, while congruence and self-esteem are not synonymous, they seem to be strongly associated.

5 The following is a brief scenario of an interspace reflection.

Joan:

"You have never understood how I felt when your mother comes to stay with us."

At first the therapist simply reflects the client's feelings:
"When you try and tell John about your feelings when your mother-in-law visits, it seems he never understands you."

Danny responds:

"I want to understand, but every time I try and talk about it, she just walks away."

Reciprocally, the therapist attends to John responding:

"When you try and understand what Joan's concerns about your mother, you feel she does not listen to your questions."

At this juncture the therapist is in the position of reflecting the interspace, accordingly:

"Whenever you two try to talk about Danny's mom's relationship with Joan there seems to be some kind of barrier between you."

Thus, the therapist hears and reflects each member's position, but goes on to reflect the interpersonal incongruence, or interspace. Ideally, each feels heard, neither is blamed, and the situation is outlined as a common problem. Although interspace reflections seem simple – almost obvious – the reduction of attribution and blame-laying creates an atmosphere for greater understanding wherein the couple's actualizing tendency can be unencumbered and change facilitated."
Policy Statement

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