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REMEMBERING ELEANOR: A DIFFERENT WAY OF CONTACT

Jerold D. Bozarth
University of Georgia

Forty years ago I was employed as a Psychiatric Rehabilitation Counselor in a State Mental Hospital. The primary clientele were individuals with chronic long term psychosis. I had no experience or supervision as a therapist or counselor, no formal group experience and had never heard of Carl Rogers. The job, however, consisted primarily of individual therapy with long term "psychotics". My role also included that of assisting individuals to undertake training, helping them to become employed and to live outside of the hospital. Most of my referrals were from patients and from ward attendants. Out of desperation and naiveté, I learned to depend upon these individuals for the direction of their lives. Out of our relationships with each other and from their own resources, many of the individuals were discharged from the hospital. Many were employed. Others significantly improved the quality of their lives. There was no systematic way that I dealt with individuals; they dictated the means, the mode and directions of contact. This way differs from McWilliams' and Prouty's "Pre-Therapy" theory of psychological contact (See this issue). They reiterate Prouty's (1994) contention that Pre-Therapy is an evolution of Client-Centered Therapy (and, in Prouty's 1994 contention, also of Experiential Therapy). I personally consider this assertion a serious non-sequitur of Rogers' theory although, perhaps, not of Experiential Therapy. The theory could easily become a resurgence of the therapist as an expert who determines contexts for the client. The theory is manifested by a "how to do it system" of making contact with clients disabled with mental retardation as well with those who are "functionally retarded". In my view, such systems may be tolerated in a client-centered framework if they do not distract from the basic thrust of the self authority of clients. This is, however, often a danger of "how to do it" guidelines (e.g., the Human Relations Models that prostitute Rogers' concepts). I am sure that the intent of the theory is to help individuals to increase the self authority of such clients. However, the internal chaos of humans is not resolved by the security of therapeutic systems and therapist expertise. My view is that the value of the Pre-Therapy system is primarily that of giving the therapist the security of something to do in order to be comfortable in the relationship. I believe that the relationship begins immediately upon contact. I disagree with McWilliams' and Prouty's conceptualization that their guidelines are preparatory to the relationship. Such a guideline is highly suggestive, albeit I suspect denied by them, that the therapeutic relationship is the verbal discourse manifested by "empathic listening". That is, the contact is made in order that more verbal connective discourse is possible.

Eleanor is one dramatic example of a less controled and less systematic way of contact. Eleanor was one of the individuals who taught me to stay dedicated to the remarkable internal resources of human beings. Eleanor was referred to me by a ward attendant who had several his "patients" improve after seeing me. She was a patient in a locked ward of a conventional state mental hospital in the 1950's. I did not know upon referral that Eleanor was functionally retarded,

hallucinatory and unable to leave the ward. I learned this fast when I entered the urine saturated atmosphere of the locked ward. I was introduced to a woman with bulging eyes and a Cheshire grin who was sitting on the floor playing with her feces. I felt that it would have been discourteous to her for me to follow my inclination to retreat. I started by sitting on a chair facing her, and eventually found myself sitting on the floor next to her. She quit playing with her feces and mainly looked at me with an incredulous grin. I explained my role of helping individuals to get out of the hospital, helping them find what they wanted to do and so on. No doubt I talked too much. "What do you think about what I am saying, Eleanor?" I asked. She smiled and uttered a guttural sound. I followed with a number of other statements that I no longer recall. Finally, just sitting there in silence in all of my anxiety and feelings of inadequacy, I spontaneously blurted, "Do you think that you might be interested in beauty school?" After a long pause, she offered an affirmative nod. We scheduled another appointment and continued to meet once a week. After about six weeks, Eleanor improved significantly in her personal hygiene and grooming, increased her verbal communication, and her hallucinations diminished . This resulted in a transfer to an open ward. She eventually obtained off grounds passes and worked in an industrial assignment in the hospital. I lost track of her when I moved from the hospital to another job. She had, however, increased the quality of her life. The moment of movement for her followed my question concerning her interest in beauty school. The statement was not very empathic nor did it have any intent to produce an effect, including "psychological" contact. We were already in relationship when contact occurred. The relationship simply continued to develop.

The scenario with Eleanor, which I use to represent other therapy relationships, is considerably different from the recommended response repertoire of the theory of Pre-Therapy. There was no theoretical intent to assist concrete reality contact, or to develop affective contact, or to assist communicative contact. Neither were there intentions to assist awareness functions or reinforce particular experiences. There was no pre-therapy preceding the relationship. We were in contact the moment I decided that I could not retreat (maybe before). I did not look for areas of behavioral confirmation as markers for success. Mostly I sat insecure, anxious about how much she might be helped, and in a muddled search for the means, medium and mode that we might extend and enrich our contact.

It is, perhaps, easier to have form and structure by which to make contact. The danger of all such systematic approaches is that the therapist in varied degrees becomes the guide, determiner and crux of success. The dedication to client self authority becomes contaminated with "how to do it" rather than with the person to person relationship even when this is not the intention of the theory.

The recent conclusions of research reviews (Duncan, Hubble & Miller, 1997; Duncan & Moynihan, 1994; Stubbs & Bozarth, 1994) on psychotherapy outcome indicate that the client/therapist relationship and client resources (extratherapeutic variables) account for seventy percent of the variance of success. Relationship, contact and connection are virtually the same phenomenon. These concepts are what goes on between the therapist and client. Differences of interacting are not predicated upon diagnoses or levels of intelligence (functional or otherwise) from a client-centered perspective. Interactions are predicated upon the particular individual rather than upon a group of individuals. The relationship, the contact, becomes different with each and every individual, noticing not particular contexts but struggling with the nuances of the relationship. I suggest that Rogers did not make much ado about contact since he did take it as a given. It is, in fact, interesting that in an early version of his (Rogers, 1957) integration article in a discussion paper (Jules Seeman, personal communication) at The University of Chicago identified this condition as, "relationship contact". In the integration article (Rogers, 1957), cited by McWilliams and Prouty, Rogers changed the term to "psychological contact". Rogers (1959)

changed this again in his actual theory statement to just, "contact". This suggests to me that he simply meant that the two individuals had to in some way be present to each other.

Some might argue that those individuals identified as "severely retarded" require a more concentrated systematic attention. I agree with my friend David Spahn, who has worked for over twenty five years with severely retarded individuals. He has often been the trouble shooter for the treatment system because he resolves problem situations through his relationships with the individuals. He notes: "Treating individuals as individuals, accepting them as human beings is more helpful than anything else." (Spahn, Personal Communication) His contact with the individuals is himself, not a preconceived system of interaction.

McWilliams and Prouty have presented a form and structure to help develop contact and more meaningful relationships with some individuals. I suggest that there are also other ways of contact, that contact is part of the relationship and that caution should be given to any pre-conceived way of being with people.

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