

My Credo as a Person-Centered Psychotherapist

Leif J. Braaten

Abstract

My task is to try to sift out the principles of therapeutic work that I am actually using in my daily work with individuals, couples, business leaders, and groups. I am allowing myself this privilege after some 50 years of dedicated person-centered activities as a clinician, academic teacher, and researcher. I have found certain principles that to me seem necessary for a truly positive person-centered outcome. Some examples are: “You Must Love People, Including Yourself,” “Offer the Client a Relationship Between Two Persons,” and “Bring to the Session Your Honest, Genuine Self.”

Introduction

My task is to try to sift out the principles of therapeutic work that I am actually using in my daily work with individuals, couples, business leaders, and groups. I am allowing myself this privilege after some 50 years of dedicated person-centered activities as a clinician, academic teacher, and researcher. I believe that I am loyal to the essence of the person-centered approach, but nevertheless open to let myself be influenced to a certain extent by other points of view. I made it my challenge to be a pioneer doing person-centered group therapy from the mid-1960s in Scandinavia and wrote a couple of books and many articles from this branch of our field. Since Rogers did not actually teach group therapy, but rather encounter groups, I

Author Note: This article was presented at the 11th International Forum for PCA in Ershovo, Russia, May 6, 2010. Address correspondence to Professor Leif J. Braaten at Hoffsjef Loevenskiolds vei 42 B, 0382 Oslo, Norway. Email: leif.j.braaten@c2i.net

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chose to become an active member in the American Group Psychotherapy Association, where all major schools were represented. In retrospect, my observation as a participant in countless groups was that most of my excellent colleagues and mentors were to a surprising degree person-centered in their basic attitudes, in spite of their diverging theoretical orientations. They were genuine in their own styles and theories, always empathic, even at very deep levels, and warmly accepting and confirming of their clients. My self-instruction for the present task is to try to be loyal to exactly my special experience, accepting that all colleagues and I must find precisely our unique version of the esteemed PCA position regarding the whole field of psychotherapy.

You Must Love People, Including Yourself

With the typical hysterical patient in old Vienna, with fathers who often committed emotional incest toward their daughters, it seemed necessary for Sigmund Freud to adopt a *neutral attitude* toward his female patients. Many years later, Bergler offered the term *benevolent neutrality*, which is a stronger term. Ferenczi had a serious feud with Freud, claiming that the typical patient needed actual love, including physical affection (de Forest, 1954). Most analysts would disagree, arguing that gratification of such a need was counterproductive. Rogers had the idea that *acceptance* of the client was a necessary attitude for successful treatment. Later in his career, he used terms like *warmth, prizing, and unconditional positive regard*. Already in Rogers (1951, pp. 160-171), he had a long, later famous quote from faculty member Ollie Bown, who felt “that the term ‘love’ ... is the most useful term to describe a basic ingredient of the therapeutic relationship.” With the typical patient in our time, who is often deprived of secure attachment and positive parental care, it is my conviction that *real love* is making all the difference in the world for an effective cure. In the American Group Psychotherapy Association and elsewhere, I have given workshops internationally in group therapy under the title “Compassion Without Being Seductive.” In deep therapy, it is of the utmost importance that the client feels free to explore all kinds of erotic feelings. At times it could even be appropriate for the therapist

to admit having erotic feelings toward the client, with the absolute assurance of not acting out affection or sex in the relationship.

For me it has been a lifelong struggle to really love myself. I was raised in a very religious family with the four absolute *moral rearmament* conditions (honesty, purity, unselfishness, and love) in order to be accepted and loved. Individual and group therapy over decades has helped me with this struggle of self-acceptance. In one special workshop combining meditation and group therapy, I was even helped to forgive myself for certain “terrible sins.” Fromm (1956) in his famous book *The Art of Loving* underscored how significant it is to work toward genuine self-love. “In order to be able to love another person, one needs first to love oneself ...” During recent years, I have been much more accepting than I was decades ago. Consequently, I am now able to love most people, even persons who are not very lovable by others. At times I am making a point of trying to find something I like—a smile, a manner, a piece of personal clothing, a personality trait. We all are longing to be seen, heard, physically touched, accepted, confirmed, prized, loved, and even applauded. To be loved takes the upper hand in significance in my opinion, even when compared to empathic understanding. Some dear PCA colleagues have throughout life been, by contrast, more concerned about accurate empathy, e.g., Brodley, Carkhuff, Truax, and others (Bohart & Greenberg, 1997).

As you can see, I have allowed myself considerable leeway to distance myself from the classic neutral attitude of the psychoanalysts. I believe clients need to meet a real person who is compassionate, without being seductive. Many person-centered therapists offer this version of person-centered group treatment, and participants seem to thrive from it. I do not consider this self-disclosure unhealthy gratification. However, as a warning, I recall a cartoon where the young man said: “I love you, I love you,” and the woman exclaimed, “Don’t you dare threaten me!” The degree of compassion must therefore be adjusted to each client.

Your Client Must Really Want to Change—Really

To me it seems a bit ironic that the person-centered Carl Rogers offered us a rather therapist-oriented theory of “the necessary and sufficient conditions for therapeutic personality change.” The therapist should offer the triad of congruence, positive regard, and empathy, whereas the client should only be anxious, or vulnerable. I have found it important to allow considerable time with clients who are vulnerable. In my own personal therapy with Carl Rogers in 1956 at the Counseling Center in Chicago, I spent five to six sessions before I exclaimed: “I now realize that I actually need your help.” The moral here is that the very fact of coming to therapy speaks louder than words and should impress us. However, it has been a relief a few times in my career when I have told my client that regretfully “I am sorry that I cannot help you!” My next move, then, is to help refer the client to someone specific who I trust can be of help. Once in my pioneer time as a university psychologist at the University of Oslo in the 1960s, I discovered within the first hour that “my client” had entered the wrong door; she expected me to offer her a flat to live in as a student rather than therapy! This lovely female is the only “normal” person who ever sat down in my professional office.

Offer the Client a Relationship Between Two Persons

We have all learned to appreciate Carl Rogers’s famous book *Becoming a Person*. This is our common predicament on this planet, Tellus: for us as professionals, and our clients, to try to become real persons. Therefore, I have always attempted to communicate that existentially we are all in the same boat. In this particular treatment situation, the therapist has the major responsibility for the treatment, whereas the client offers himself or herself as best they can. I am trying to avoid the implication that I am the expert and my poor client is rather helpless. One of the most challenging principles of the PCA is exactly the opposite: that the client knows best. We are only facilitators. But my emphasis goes beyond that. I would like to see us as *traveling companions in the journey of life*, being almost equal partners. At this juncture, I would like to mention my use of *the technique of bridging* (Ormont, 1997): trying to find some experience in my life which can

help me to better understand, also emotionally, my client's communications. I shall return to this topic later.

Bring to the Session Your Honest, Genuine Self

My observation over decades of participation, especially in groups, watching the clinicians as leaders, is that most of them are too restrained in their responses to clients. This is especially true of psychoanalysts, who emphasize transference. If part of our job is to model a somewhat fully functioning person, it seems to me that we should stretch ourselves toward being more our honest, genuine selves. I trust myself that my basic commitment to acceptance and empathy will allow me to use more of my total self to the benefit of clients. By contrast, I still recall my first period at the Counseling Center in Chicago in the mid-1950s, where we were instructed to choose the one perfect response to whatever the client had communicated. We were stuck acting the perfect role of the client-centered therapist. Furthermore, if you have developed an honest, genuine self, in research I seriously question if it is possible for the same person to offer client-centered therapy first and then switch to, for example, rational-emotive treatment as an alternative for comparison. This is a critique of studies trying to compare the effectiveness of various treatment methods with the same therapists.

Treat Your Client as an Equal Partner

During our early years as therapists, I think we were struggling to free ourselves from the medical model, in which the doctor always knows best. Currently even doctors have been taught to listen more accurately to their patients in order to build a more correct picture of what kind of person the patient is. I have over many years increasingly been struck with how much helpful insight clients can contribute, especially if we give them time enough. In my favorite work as a group therapist, I have settled on three-hour sessions, without interruptions, and have learned that the truly breakthrough communications often emerge during the last half hour of the session. Also in individual and couples therapy, I often use two-hour sessions, especially in the beginning, with comparable productive benefits. In both settings, my

profound experience is that we are doing the job of therapy together. Once you have learned your lesson about the power of the client, you automatically exploit it by expecting a responsible cooperation.

Never Forget that Most Clients Are Anxious or Vulnerable

Quite a few clients, including myself as mentioned above, may appear quite self-sufficient early in treatment, but we are really quite vulnerable. Behind the psychic defenses, we are anxious, depressed, compulsive, withdrawn, etc. We as clinicians are different from ordinary people in that we know about mental disorders, and instead of being threatened we react with curiosity and compassion to our clients in order to be helpful. The reason why we often succeed helping clients is our knowledge and training, but also the structure of the relationship, and endless time. I still remember Carl Rogers after the 50-minute hour with me saying: "Same time next week, Leif?" We as clients were given the privilege to terminate the treatment. I have lived after this principle, even in cases when I feel a good enough job has not quite been done.

Offer Elementary and Advanced Forms of Empathy

In ordinary life, surprisingly few people have the capacity and habit of showing empathy to other persons. They are so preoccupied with asserting themselves, being seen and heard by their fellow man. Therefore, clients are quite impressed by our consistent empathy from hour to hour. Client communications have two extremes: being purely cognitive or the opposite, purely emotional. With a cognitive person, we must be alerted to moments when the client shows feelings and respond to them. With a client who is very emotional, our responses must mirror this way of being. We must pick up the affect; the words are not so important. Of course, mostly communications are both cognitive and emotional, and then our responses must be offered as a proper mixture. I use, as a metaphor, throwing darts. If I only get a 4 from my client a particular time, I typically try again, attempting to obtain a 7 or an 8. Occasionally, I obtain a 10 response, and then I feel real satisfaction.

One important message to colleagues is that I believe empathy can be offered at several levels. The most basic level is empathy in the immediate context of interaction in a particular hour, what Rogers early on called *reflection of feelings*. Becoming aware that many clinicians adopted this only as a technique, he chose later to emphasize *the orientation or attitude of empathy*. Rice (1974) advocated paying attention to *evocative reflection*. In his last years, Rogers (1980) coined the term *intuitive empathy*. I also like the name of *empathic attunement* of Kohut (1984). Other versions of this therapeutic attitude have been called *mutual empathy* (Jordan, et al., 1991) and *relational empathy* (O'Hara, 1995).

In my therapy with Carl Rogers in the 1950s, struggling with my grandiosity, he once made the following empathic remark: "If you cannot become equally successful and famous like me as a psychologist, life is not worth living!" I could have killed Carl for that response, because he hit the nail on the head. He had probably built up a picture of me during several hours, and therefore the high level empathic response in context was so powerful. I found myself during the recent decade at times attempting to be empathic in regard to manner, total appearance, relational style, character, degree of presence in the hour, and attachment style.

One afterthought in my own therapy with Carl was that he never cared to explain his possible thoughts about why I cried so much during the first part of my treatment. Decades later in life, with the help of other professionals, I discovered that I carried with me to my therapy with Carl buckets of held back tears from my infant period, when my mother collapsed and had to leave me, a vulnerable infant, to other helpers. Carl released those tears when I was in my mid-20s. He was always a true master of getting at the significant feelings of clients. In recent years, Elliott and Greenberg have developed a more detailed version of the PCA approach called *emotion-focused therapy*.

The Client Longs to be Accepted, Prized, Confirmed

As mentioned previously, I believe that most clients deep down have a desire, a longing, to eventually be accepted as the persons they honestly are. At the bottom of most psychopathology, I believe, the basic trauma in life is *not* being seen and accepted, but rather being

ignored, misconstrued, and often rejected. Most parents have a catalogue of what Stanley Standal and Carl Rogers called *conditions of worth*. I can still remember how surprised I was in therapy with Carl, being unable to detect that he had a specific vision of the future person I ought to be. Precisely here, in this context, it is fitting to suggest that Carl probably would have appreciated the very idea that I am attempting to articulate my credo. Unlike Sigmund Freud and many other pioneers in our field, Carl did not strive to develop person-centered disciples. In a plenary PCA session in Great Britain many years ago, he was quite provoked by our collective efforts to create national and international organizations for the person-centered point of view. In relation to this obvious need for structure, it seemed for Carl as if it would be enough to simply have him around—forever. I am very alerted to signs of progress as experienced by clients and try to acknowledge and share the joy of such positive achievements.

Offer the Client a Secure Attachment

A very common, fundamental trauma of many clients is an insecure or lacking attachment to significant others, especially the mother or the father. In the light of this unlucky start in life, it is of the utmost importance that we as therapists are really trustworthy. We must offer a structured relationship, keep strict boundaries, and be absolutely consistent in our treatment behavior. A highly respected PCA colleague, J. D. Bozarth, once wrote a poem in which he talked about the *validity of the moment*. In this poem, he expands on the theme of attachment to include our different identifications, offering as therapists to be mother, father, sister, brother, friend, child, and lover. We all have *multiple selves* (Polster, 1995), and ideally each one of these selves ought to be confirmed and honored.

Be Supportive of Humor, Smiles, and Laughter

Psychotherapy has traditionally been a very serious business. Especially during the last decade after having entered the stage of professor emeritus, I have increasingly allowed myself, when it has seemed appropriate, to sprinkle my sessions with spontaneous humanity, humor, smiles, and laughter. To exaggerate, I consider a

session “a failure” if I have not found one single opening for this lighter touch. Again, I am reminding us about the opportunity of modeling a somewhat fully functioning person, which always includes both tears and laughter. In my professional work as an academician, I have for decades allowed myself to sprinkle my contributions with delightful cartoons.

Allow Considerable Technical Freedom in Therapy

In order to become a skilled and effective psychotherapist, it is absolutely essential that you acquire a solid, basic training. I had such a thorough training in the person-centered approach in the late 1950s at the Counseling Center in Chicago with Carl Rogers, his staff, and scores of graduate students from all over the world. It included lectures, audiotapes, films, clinical practice with supervision, and research, typically with a Ph.D. as a result. When I returned to Norway, I wrote a book on the person-centered approach for Scandinavian colleagues and readers. I taught person-centered therapy for Norwegian students more than three decades and was invited as guest professor to visit several universities in Sweden and Denmark. During these decades, I felt it was my sacred duty to teach the correct client-centered approach.

Partly to challenge myself, I set out to become a pioneer offering group therapy to clients. As mentioned previously, Rogers was more into encounter groups and even became sort of a guru for that movement and did not ever train his students in group therapy. In order to find a secure training ground for myself, I became a very active, dedicated member of the well-managed American Group Therapy Association for more than 30 years. My experience, for what it is worth, has been that many of my group therapy leaders and mentors seemed quite client-centered in their basic attitudes, regardless of their theoretical orientations. I must admit that I have learned to appreciate a number of techniques that are allegedly foreign to the person-centered approach, such as transference, counter-transference, interpretations, meditation, re-decision treatment, bridging, and the mother group. In some connections, I allow myself the freedom to supplement our standard techniques with some of these techniques.

As a Therapist You Are Responsible to Your Client

One of Freud's most brilliant and helpful concepts was *the idea of transference*. He was not so conceited that he believed that many of his female patients in Vienna actually fell in love with him. He documented through countless cases that they transferred their feelings toward father and mother to their therapists. Freud helped out Breuer with the concept of transference when Breuer, quite shocked, reported that one of his patients wanted to have a child with him. Freud took over the patient, and Breuer fled to Italy on a second honeymoon with his wife. Sometimes I experience it as quite a relief when I suspect transference of a strong affect, and the client actually admits that it is true. I remember one colleague in Austria at an international congress early in my career claiming that *all communications by patients were transference*. Of course in recent decades, we have a more sophisticated view of this phenomenon and talk about both transference and counter-transference. The person-centered view is that you are responsible for your actual behavior with clients and must be prepared to take the consequences. It is very significant for clients to be confirmed and verified that the therapist occasionally might be distant, sleepy, seductive, hostile, etc. At the deepest level, it is a question whether the client perceives reality correctly. The therapist must be humble enough to admit that he or she is only a human being and sometimes is failing to be optimally helpful. This humility at times will help clients to correct for their own perfectionism.

Therapist Self-Disclosure Helps Build a Working Alliance

I have already discussed the self-disclosure of therapists and believe that such a technique often helps build a good working alliance with clients. I feel that clients need both our humanity and our professional skills. But our critics assert primarily that even small bits of self-disclosure might destroy the power of transference. The basic premise of this technique is that the client should not be offered anything personal or private from the helper. A danger with self-disclosure is that the professional might exploit the client for his own unfulfilled needs. At this junction, it seems appropriate to warn us about acting out when we have too many frustrations in our own lives.

For the therapist to have a fulfilling personal life is a real advantage in order to be able to help others. Most therapists seek treatment themselves to work through their emotional problems. Let me conclude that I believe that selective self-disclosure, triggered by the here and now in a particular session, can contribute to strengthening the working alliance, which according to clinical experience and research is fundamental in order to have progress in treatment.

Bridging Can Improve the Empathic Understanding

As mentioned earlier, bridging, according to Ormont (1997), is the technique for the therapist to find a personal experience, recollection, etc., which naturally resembles and connects with the actual experience of the client. Let me use a personal example. When I returned to Norway in 1964, after eight years in the United States, I had, as seen in retrospect, at least a subclinical depression for several months. I discovered that I subjectively felt I had lost my hard-won American identity. For a couple of years, I was only an assistant professor before I was promoted to associate professor, the status I held at Cornell University. My psychoanalytical colleagues in Norway met with real skepticism my belonging to the popular person-centered point of view of the world-known authority Carl Rogers. The turning point appeared when I suddenly felt so bored by being locked into my sadness and feeling of loss. From that moment on, I took responsibility for myself, becoming quite self-assertive all across my life, and made fine progress in many ways. This experience has helped me countless times in order to really get the feel of being depressed. In addition, I would like to share the caption of one of my favorite cartoons, where my client exclaims, "Don't you dare take away from me my depression!" My definite lesson in life is that most depressions run through certain stages and must be allowed to take enough time.

Offer Self-Actualization and a Positive Psychology

In contrast to psychiatry in general and many viewpoints of psychotherapy, I do not emphasize sickness, neurosis, personality disorders, and psychopathology in my work. Even with heavy cases, I am looking for the positive signs of mental health, coping, and the

good life. A very good friend and colleague of mine, who has been the Norwegian guru of modern psychoanalysis, once told us at my farewell dinner from the University of Oslo that he at times felt a bit envious of me, often hearing laughter and joy from our person-centered quarters in the same building. However, being client-centered certainly implies that we go with the clients and, of course, take their emotional problems very seriously. Here I must admit that I have never dared to work within a psychiatric hospital, fearing that I would not be able to stand my ground and keep my sanity having to work with the sickest of all patients. In contrast I have about half my time tried to be helpful with consulting and group work to more or less normal business leaders.

Allow Pursuing the Goals of Person-Centered Psychotherapy

We all recall the concept of *the fully functioning person* of Carl Rogers, in which he listed the three qualities of *openness to experience, congruence, and existential living*. In my own work, I have tried to articulate the movements and goals of many hundreds of clients during my career, also mirroring the zeitgeist of our own time. I have been struck by how my clients all struggle to develop a healthy, personal identity, with their own values, interests, and life priorities. At this point it seems fitting to remind us about Erik Ericsson's assertion that *identity must be secured before intimacy*, a realization which is of utmost significance in couples therapy. The second major goal is to develop a capacity for deep, enduring, intimate relationships with positive emotions, a sense of flow, and a meaningful life. This conclusion reminds me about a theoretical distinction I developed in my doctoral thesis in Chicago in the 1950s, where I found it helpful for research purposes to distinguish between a private, inner self, and a social self.

Conclusion

I can see a connection between my therapy with Rogers in the 1950s in Chicago and this mature attempt to articulate my credo as a person-centered psychotherapist. In Chicago I received excellent help to find my true, inner self—also the confidence that I actually was Ph.D. material. After a lifetime as a therapist for individuals, including mature singles, couples, and business leaders, emphasizing group therapy teaching hundreds of persons to become professional clinical psychologists as a professor at the University of Oslo; and considerable researching and writing on therapy, I find myself still basically person-centered in my approach. I believe that if you have a thorough fundamental training as a clinician, then you can allow yourself considerable freedom technically. I would recommend some senior colleagues to try to articulate their unique credos, because it is such a rewarding endeavor. I trust that Rogers would have appreciated our integrity attempting to perform such a significant task.

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