Authenticity, Congruence and Transparency

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Although Rogers had always attached great importance to the therapist's authenticity (see for example Rogers, 1951, p. 19), it was not until his 1957 paper about the 'necessary and sufficient conditions' that he mentioned it explicitly as a separate therapeutic condition, along with empathy and acceptance. From 1962 on, he even called it the most fundamental of all three basic attitudes, and continued doing this in his later works. Here is how Rogers describes it:

> *Genuineness in therapy means that the therapist is his actual self during his encounter with his client. Without facade, he openly has the feelings and attitudes that are flowing in him at the moment. This involves self-awareness; that is, the therapist's feelings are available to him to his awareness - and he is able to live them, to experience them in the relationship, and to communicate them if they persist. The therapist encounters his client directly, meeting him person to person. He is being himself, not denying himself.*
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> *Since this concept is liable to misunderstanding, let me state that it does not mean that the therapist burdens his client with overt expression of all his feelings. Nor does it mean that the therapist discloses his total self to his client. It does mean, however, that the therapist denies to himself none of the feelings he is experiencing and that he is willing to experience transparently any persistent feelings that exist in the relationship and to let these be known to his client. It means avoiding the temptation to present a facade or hide behind a mask of professionalism, or to assume a confessional-professional attitude.*
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> *It is not simple to achieve such reality. Being real involves the difficult task of being acquainted with the flow of experiencing going on within oneself, a flow marked especially by complexity and continuous change ... (1966, p.185.)*

This definition implies clearly that genuineness has two sides: an inner one and an outer one. The inner side refers to the degree to which the therapist has conscious access to, or is receptive to, all aspects of his own flow of experiencing. This side of the process will be called 'congruence'; the consistency to which it refers is the unity of total experience and awareness. The outer side, on the other hand, refers to the explicit communication by the therapist of his conscious perceptions, attitudes and feelings. This aspect is called 'transparency': becoming 'transparent' to the client through communication of personal impressions and experiences. Although this splitting up of genuineness into two components may be slightly artificial, we find it justified from a didactic point of view as well as clinically meaningful. Indeed, a congruent therapist may be very or minimally transparent, according to his style or orientation; a transparent therapist may be congruent, or he may be incongruent (something which makes him or her a 'dangerous' therapist). In a first point, we will discuss the concept of congruence, which has always been given the most weight in Rogers' definition. In a second one, we will then deal with transparency.

1. Congruence

Why did Rogers come to attach so much importance to the therapist's congruence, and why did he even come to see it as the most fundamental basic attitude? We hope to answer this question gradually, while further explaining the concept itself.

Personal Presence

Rogers was always opposed to the idea of the therapist as a 'white screen'. He designed a 'face-to-face' type of therapy, in which the therapist is highly involved with the client's experiential world, and in which he, consequently, shows little of himself. Yet he does show his involvement in an open and direct way, without hiding his real feelings behind a professional facade. He tries to be himself without artificiality and haziness. By adopting such a 'natural', spontaneous attitude, the client-centred therapist certainly does not favour the process of regression and transference; but Rogers did not see this 'detour-process' as essential to personality change. More than the psychoanalysts, he believed in the therapeutic value of a 'real' relationship between client and therapist, and saw other, more important advantages in it as well. In such a working relationship, the therapist serves as a model: his congruence encourages the client to take risks himself in order to become himself. Along with this, Rogers gradually came to consider the therapist's congruence as a crucial factor in establishing trust, and came to emphasise the idea of acceptance and

empathy only being effective when they are perceived as genuine:

> *Can I be in some way which will be perceived by the other person as trustworthy, as dependable or consistent in some deep sense? Both research and experience indicate that this is very important, and over the years I have found what I believe are deeper and better ways of answering this question. I used to feel that if I fulfilled all the outer conditions of trustworthiness - keeping appointments, respecting the confidential nature of the interviews, etc. - and if I acted consistently the same during the interviews, then this condition would be fulfilled. But experience drove home the fact that to act consistently acceptant, for example, if in fact I was feeling annoyed or sceptical or some other non-acceptant feeling, was certain in the long run to be perceived as inconsistent or untrustworthy. I have come to recognise that being trustworthy does not demand that I be rigidly consistent but that I be dependably real. The term 'congruent' is one I have used to describe the way I would like to be. By this I mean that whatever feeling or attitude I am experiencing would be matched by my awareness of that attitude. When this is true, then I am a unified or integrated person in that moment, and hence I can be whatever I deeply am. This is a reality which I find others experience as dependable. (Rogers, 1961, p.50.)*

This also means that the therapist should give priority to discussing his own feelings whenever they persistently stand in the way of the other two basic attitudes. Initially, Rogers considered such moments of self-expression as a 'help in need', as a therapist's last resort in discarding obstacles to his involvement with the client's experiential world. Gendlin, on the other hand, emphasises more the gain, for therapist and client, resulting from daring to present oneself as 'not perfect':

> *'Congruence' for the therapist means that he need not always appear in a good light, always understanding, wise, or strong. I find that, on occasion, I can be quite visibly stupid, have done the wrong thing, made a fool of myself. I can let these sides of me be visible when they have occurred in the interaction. The therapist's being himself and expressing himself openly frees us of many encumbrances and artificialities, and makes it possible for the schizophrenic (or any client) to come in touch with another human being as directly as possible. (Gendlin, 1967, pp.121-22.)*

The personal presence of the therapist should also be apparent from his concrete methodology, from the specific interventions and procedures used to facilitate and deepen the client's discourse. Important here is that the 'technique' should rest on an underlying attitude, that the therapist should stand behind it with his whole being (Kinget, 1959, p.27), and that his work method should suit his personality. Rogers noticed 'with horror' in some of his pupils how reflecting feelings had deteriorated into aping, into a 'wooden technique', no longer carried by an inner attitude which emanates from an attempt to understand and check this understanding (Rogers, 1962, 1986; Bozarth, 1984). Rogers' view on the therapist's contribution thus increasingly evolved towards a metatheory, in which a number of basic attitudes are emphasised and in which concrete recipes and formulas of intervention have faded into the background. Gendlin writes about this evolution:

> *Gone are formulas - even that most characteristic of client-centred modes of responding, which was called 'reflection of feeling'. As the term 'empathy' implies, we strive as always to understand and sense the client's feeling from his own inward frame of reference, but now we have a wider scope of different behaviours with which therapists respond to clients. In fact, I believe that it was in part the undesirable tendency toward formulas and stereotyped ways of responding which perhaps led Rogers to formulate this condition of 'congruence' as essential. (Gendlin, 1967, p.121.)*

Because of the prime importance of the therapist's authenticity - but also perhaps because he was no great believer in the power of technique per se - Rogers thus emphasises respect for each therapist's personal style. He does not want to put him in a methodological strait-jacket which would not suit his nature. That he is very broad-minded about this becomes obvious, for instance in his comment about the often widely diverging working methods of the therapists in the schizophrenic study:

> *Perhaps the deepest of these learnings is a confirmation of, and an extension of, the concept that therapy has to do with the relationship, and has relatively little to do with techniques or with theory and ideology. In this respect I believe my views have become more, rather than less, extreme. I believe it is the realness of the therapist in the relationship which is the most important element. It is when the therapist is natural and spontaneous that he seems to be most effective. Probably this is a 'trained humanness' as one of our therapists suggests, but in the moment it is the natural reaction of this person. Thus our sharply different therapists achieve good results in quite different ways. For one, an impatient, no-nonsense, let's put-the-cards-on-the-table approach is most effective, because in such an approach he is most openly being himself. For another it may be a much more gentle and more obviously warm approach, because this is the way this therapist is.*

Our experience has deeply reinforced and extended my own view that the person who is able openly to be himself at that moment, as he is at the deepest levels he is able to be is the effective therapist. Perhaps nothing else is of any importance (Rogers, 1967, pp.185-86.)

As will be discussed further on, this respect for the therapist's own style is no passport to 'reckless experimenting'. Attention to the client's process and continuous following of his experiential track remain the ultimate guidelines for our interventions.

Congruence As Conditio Sine Qua Non of Acceptance and Empathy

After having examined the therapist's congruence from the angle of his 'personal presence', we now wish to inquire about the core meaning of the concept and discuss its importance for therapeutic work. Congruence requires, first of all, that the therapist be a psychologically well-developed and integrated individual, i.e. sufficiently 'whole' (or 'healed') and in touch with himself. This means amongst other things daring to acknowledge flaws and vulnerabilities, accepting the positive and negative parts of oneself with a certain leniency, being capable of openness without defensiveness to what lives in oneself and being able to get in touch with it having a solid identity and a strong enough sense of competence, being able to function efficaciously in personal and intimate relationships without interference from one's own personal problems. Self-knowledge and ego-strength can perhaps be seen as the two cornerstones of this way of being (see e.g. McConnaughy, 1987)

Congruence is a correlative of acceptance: there can be no openness to the client's experience if there is no openness to one's own experience. And without openness there can be no empathy either. In this sense, congruence is the 'upper limit' of the capacity for empathy (Barrett-Lennard, 1962, p.4). To put it differently: the therapist can never bring the client further than where he is himself as a person.

Incongruence

The importance of this attitude becomes especially clear when it is lacking, i.e. when the therapist is defensive and incongruent. Our personal difficulties may sometimes prevent us from letting the client's experience emerge fully, as it is. Life issues with which we have not dealt yet, personal needs which play along during therapy, personal vulnerabilities and blind spots, all may cause us to feel threatened and unable to follow with serenity certain experiences of our client (Tiedemann, 1975). To empathise with the experiential world of another person with values vastly different from our own, to let feelings of powerlessness and hopelessness emerge, to empathise with intense happiness, to deal without undue defensiveness with a client's intense negative or positive feelings towards us, all this is not easy. Because of our own experience of threat and defensiveness, there is a danger of us being so busy maintaining our own equilibrium that we break the deepening of the client's self-exploratory process either by keeping too much distance or by losing ourselves in the other. Rogers puts it as follows:

Can I be strong enough as a person to be separate from the other? Can I be a sturdy respecter of my own feelings, my own needs, as well as his? Can I own and, if need be, express my own feelings as something belonging to me and separate from his feelings? Am I strong enough in my own separateness that I will not be downcast by his depression, frightened by his fear, nor engulfed by his dependency? Is my inner self hardy enough to realise that I am not destroyed by his anger, taken over by his need for dependence, nor enslaved by his love, but that I exist separate from him with feelings and rights of my own? When I can freely feel this strength of being a separate person, then I find that I can let myself go much more deeply in understanding and accepting him because I am not fearful of losing myself. (1961, p.52.)

All this means that we, as therapists, need strong ego boundaries. An important part of being a therapist is to have the capacity to be steady as a rock (Cluckers, 1989): we sometimes have to pull the chestnuts out of the fire, deal with stormy emotions without being engulfed, deal constructively with hate and love without resorting to acting-out, deal with the client's praise and criticism of our own person; and we have to be able to tolerate ambivalence. To share empathically the other's world also implies putting our own world in parentheses, for the time being, and 'risking' personal change through contact with someone who is different from ourselves. Venturing in such an 'egoless state' (Vanaerschot, 1990) is easiest when we feel ourselves to be a sufficiently separate person with a well-defined personal structure and nucleus. Finally, we wish to point to a last aspect which demands a certain strength from the therapist: the fact that the client's discourse can be confronting to the therapist in so far as it addresses dormant issues in himself. Rombauts relates this being confronted with oneself to the kinship which exists between client and therapist, in the sense that both 'share a human existence'. He writes:

Because of this kinship, it is not only me who holds up a mirror to the client (although I find

'mirroring' a poor term), but also the client who holds up a mirror to me, showing me what I am, feel and experience. Dormant aspects of myself, which I have barely or not at all realised in my own life, can be touched upon and stirred up. As a consequence, I am constantly being confronted with myself when doing therapy, and led to question myself. Something happens, not only to the client but also to the therapist. We are companions-in-fate, in life as well as in therapy. (1984, p.172.)

Congruence and Empathy

As we have seen, a lack of congruence undermines our therapeutic work. We can perhaps even better illustrate the importance of congruence from a positive angle or, at any rate, draw attention to a few aspects which we have not discussed yet, and which have a lot to do with the quality of our empathic interventions. A high level of congruence certainly guarantees a personal flavour to the communication of empathy so it would not be experienced by the client as a stilted application of technique. Indeed, the client finds himself faced with a therapist who is 'rooted' in his own experience, and who is, from there, trying to understand his message. The therapist not only summarises the client's words, but puts into words 'what strikes him', what the client's discourse evokes in him, how it makes him feel', what he does not yet understand perhaps, but would like to understand, etc. Even though the therapist is in essence focused on the client's experiential world, the understanding is always a personal one, in the sense that his interventions originate in his own experience of what the client tells him. Occasionally (in my opinion very exceptionally) this can result in the therapist briefly mentioning an experience of his own, not in order to talk about himself or draw attention to himself, but as a way of letting the client know that he has been understood. This personalised form of empathy can perhaps best be illustrated by a couple of fragments from a session with 'A silent young man', where Rogers tries to share the feelings of hopelessness and rejection experienced by Jim Brown (see especially the T-interventions with an asterisk).

C: I just want to run away and die.

T: M-hm, m-hm, m-hm. It isn't even that you want to get away from here to something. You just want to leave here and go away and die in a corner, hm?

(Silence of 30 seconds)

*T: I guess as I let that soak in I really do sense how, how deep that feeling sounds, that you - I guess the image that comes to my mind is sort of a, a wounded animal that wants to crawl away and die. It sounds as though that's kind of the way you feel that you just want to get away from here and and vanish. Perish. Not exist.

(Silence of 1 minute)

C: (almost inaudibly) All day yesterday and all morning I wished I were dead. I even prayed last night that I could die.

*T: I think I caught all of that, that - for a couple of days now you've just wished you could be dead and you've even prayed for that - I guess that - One way this strikes me is that to live is such an awful thing to you, you just wish you could die, and not live.

C: I ain't no good to nobody, or I ain't no good for nothin', so what's the use of living?

T: M-hm. You feel, 'I'm not any good to another living person, so - why should I go on living?'

(Silence of 21 seconds)

*T: And I guess a part of that - here I'm kind of guessing and you can set me straight, I guess a part of that is that you felt, 'I tried to be good for something as far as he was concerned. I really tried. And now - if I'm no good to him, if he feels I'm no good, then that proves I'm just no good to anybody.' Is that, uh - anywhere near it?

C: Oh, well, other people have told me that too.

T: Yeah. M-hm. I see. So you feel if, if you go by what others - what several others have said, then, then you are no good. No good to anybody.

(Silence of 3 minutes, 40 seconds)

*T: I don't know whether this will help or not, but I would just like to say that - I think I can understand pretty well - what it's like to feel that you're just no damn good to anybody, because there was a time when - I felt that way about myself And I know it can be really rough. (Comment: This is a most unusual kind of response for me to make. I simply felt that I wanted to share my experience with him

- to let him know he was not alone.) (Rogers, 1967, pp.407-09.)

Deep empathy always means 'listening with the third ear', in which a regressive contact with one's own deeper feeling levels and the ability to imagine what one would feel in a similar situation are important elements. Rogers (1970) describes how he gradually developed more confidence in his own deeper intuitive levels:

> *I trust the feelings, words, impulses, fantasies, that emerge in me. In this way I am using more than my conscious self, drawing on some of the capacities of my whole organism. For example, 'I suddenly had the fantasy that you are a princess, and that you would love it if we were all your subjects.' Or, 'I sense that you are the judge as well as the accused, and that you are saying sternly to yourself, "You are guilty on every count."'*
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> *Or the intuition may be a bit more complex. While a responsible business executive is speaking, I may suddenly have the fantasy of the small boy he is carrying around within himself - the small boy that he was, shy, inadequate, fearful - a child he endeavours to deny, of whom he is ashamed. And I am wishing that he would love and cherish this youngster. So I may voice this fantasy - not as something true, but as a fantasy in me. Often this brings a surprising depth of reaction and profound insights. (p.53.)*

Gendlin too (1967) describes how a therapist may empathically guess, on the basis of his own stream of thoughts and feelings, what the client is going through, or can try to evoke the felt sense of what the client says:

> *The patient talks, perhaps gets much value from having a friendly caring listener, but nothing of therapeutic relevance is said. There is only talk about hospital food, the events of the week the behaviour of others, a little anger or sadness, no exploration I become the one who expresses the feelings and felt meanings I say, 'What a spot to be in' or, 'Gee, and they don't even care what you think about it,' or 'I guess that leaves you feeling helpless, does it?' or, 'Boy, that would make me mad,' or, 'It must be sad that he doesn't care more for you than that,' or, 'I don't know, of course, but I wonder, do you wish you could get mad, I but maybe you don't dare?' or, 'I guess you could cry about that, I if you let yourself cry.' (p.398.)*

All this goes to show that congruence and empathy are not opposites. On the contrary, empathy is always implicitly carried by the therapist's congruence: we always understand the other via ourselves, through our kinship as fellow human beings (see Vanaerschot, 1990). So far we have discussed the importance of congruence mainly in the context of acceptance and empathy for the client's experiential world, disregarding the interaction here-and-now. However, empathy for what happens between client and therapist, for the kind of relationship pattern which they create in their influence on each other, is an equally important aspect of the process, and here too - maybe especially here - the therapist's congruence is crucial. Indeed, here it functions as an 'interactional barometer' for what happens in the relationship. We will discuss this aspect later, under the heading 'Transparency'.

Implications for Training and Professional Practice

Personal maturity, together with the basic clinical aptitudes related to it, can thus be considered as the therapist's main instrument in client-centred therapy. In this respect, we share the view of psycho-analysts. It should thus not come as a surprise that, in our training, special attention is paid to the personal development of the therapists to-be. We are, of course, not talking here about 'direct training in congruence, but about the slower and indirect ways of personal therapy and personalised supervision, in which the person of the therapist is as much focused on as the client's process. As far as personal 'didactic' therapy goes, I myself am strongly in favour of participation in intensive long-term group therapy. Indeed, therapeutic experience in a group offers, more than individual therapy, the possibility of observing one's own interpersonal functioning, something which is crucial for therapeutic work (see also Bolten, 1990). Individual therapy may then remain highly desirable, along with group therapy, but it may not be essential for every trainee.

The willingness to work on one's own personality development should not be limited to the training period, but should be viewed as a life task'. Therefore, regular peer-review, either within one's own team or outside it, seems highly desirable. A sufficiently safe atmosphere is however a must, in order to allow the taking of personal risks and the acceptance of a vulnerable position. In a broader sense, we, as therapists, should take special care of ourselves, and watch out for signs of overburdening, loneliness, alienation, and of getting stuck in personal problems. When our need is too big, we may not have enough energy left to turn towards our client with serenity. What could we then do to avoid such impasses? 'Caring' for one's own personal relationships, re-entering therapy before it is too late, cutting one's workload and making time to be

with oneself ... may, besides supervision, already achieve a great deal. Exceptionally, changing an appointment with a client may be indicated. Besides this, it may help a great deal to 'prepare' oneself before an interview. Rombauts writes about this:

> *It seems important that I stop all my other activities, even if only a few minutes before, in immediate preparation for the contact with a client. I try as much as possible to step out of my own world, and let my worries and concerns fade into the background. I also concentrate mentally on my client, for example by recalling our last session, but also more generally by letting him be present, as it were, with everything he evokes in me in terms of memories and feelings. To use Gendlin's terms, I turn towards the 'felt sense' for the client, which lives in me.*
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> *In this way, I try to increase my receptivity towards the client, and remove as much as possible any lack of openness I may feel. However, should I not have succeeded, the first few moments of the session are often enough to create more openness, not only towards my client but also towards myself. There exists thus an interaction: the state of fundamental openness in my personal world is the soil on which the contact with the client grows; but also, this contact, this therapeutic involvement, highly enhances the quality of the openness in my personal world. (1984, p.170.)*

All this leaves us perhaps with the impression that the therapist should be a 'superman'. But this is not what Rogers and others had in mind. It is indeed so that someone who wants to become a therapist has to be prepared to go through life paying sufficient attention to his own inner life and his way of relating to others. He also has to be, generally speaking, quite sturdy. This however does not mean that he could not have problems which may at times be quite acute. The important point here is not to avoid these problems, to dare scrutinise them, to remain open to critical feedback, to learn to see how one's difficulties interfere with one's therapeutic work, and to do what is needed to remedy the situation. It is furthermore important to get to know and accept with leniency our own limits: we do not have to be able to work well with all types of clients. We may try to change our limits, but learning to know and accept them is not an unimportant task during training and beyond.

And, to conclude, I want to mention this: client-centred literature contains little in the way of the concrete forms which incongruence can take. As a process-oriented theory of therapy, it emphasises mainly the formal signals. We can see this, for example, in Barrett-Lennard's definition of incongruence:

> *Direct evidence of lack of congruence includes, for example, inconsistency between what the individual says, and what he implies by expression, gestures, or tone of voice. Indications of discomfort, tension, or anxiety are considered to be less direct but equally important evidence of lack of congruence. They imply that the individual is not, at the time, freely open to awareness of some aspects of his experience, that he is lacking in integration and is, in some degree, incongruent. (1962, p.4.)*

In the psychoanalytic literature, however, a great deal is said about the diversity in content of 'countertransference reactions' and their psychogenic roots; the interested reader may find a great deal in the following publications: Glover, 1955; Groen, 1978; Menninger, 1958; Racker, 1957; Winnicott, 1949.

2. Transparency

Its Place In The Evolution Of Client-Centred Therapy

At the beginning of this paper, I have described transparency as the outer layer of authenticity: the explicit communication by the therapist of his own experiences. It should however be mentioned that even without the use of such explicit 'self-revelations', the client-centred therapist is fairly transparent to his client, and that the distinction we made between congruence and transparency should not be understood in absolute terms. Our client gets to know us through everything we do and don't do, be it verbal or non verbal. Especially in client-centred therapy, where the working relationship is heavily coloured by personal involvement with the client on the basis of one's own experience of the moment, the client is likely to get to know who the therapist is, as a person. We can thus never function as a white screen. Each therapist evokes slightly different feelings in his clients, and this is perhaps an important element in the success or failure of a therapy, an element which surpasses concrete methods and interventions: does the client meet a therapist whose personality and way of being-in-the-world allow him to move, precisely at the level where his own problem lies? We have but little control over this aspect of therapy, and research on the topic of treatment recommendations yields but little useful information on this topic.

As to the therapist's self-expressive interventions in the narrow sense of the word, it is remarkable how reluctantly they were introduced and accepted in the evolution of client-centred therapy. This should not surprise us. Indeed, it belongs to the nuclear identity of client-centred therapy that the therapist follow his

client within the client's own frame of reference. However, between 1955 and 1962 this principle became more flexible. Client-centred therapy evolved from 'non-directive' to 'experiential', and this allowed the therapist to bring in something from his own frame of reference, as long as he kept returning to the client's experiential track (Gendlin, 1970). This was thus the context in which self-expressive interventions became accepted. Thus, we deal here with interventions where the therapist starts from his own frame of reference, as is also the case in interpretations, confrontations and proposals for the use of particular techniques, for instance. Gradually, the expression of personal feelings became no longer restricted to being a 'help in need', i.e. used in cases where the therapist could no longer genuinely accept and empathise, but it became thought of as having positive potential for deepening the therapeutic process. What the therapist experiences in contact with his client is now considered as important material and potentially useful for the client in his exploration of himself and his relationship patterns (for a thorough analysis of Rogers' evolution in this regard, see Van Balen, 1990). And Rogers attributes, in a more general way, a modelling function to the transparency of the therapist as well.

> *It is not easy for a client, or for any human being, to entrust his most deeply shrouded feelings to another person. It is even more difficult for a disturbed person to share his deepest and most troubling feelings with a therapist. The genuineness of the therapist is one of the elements in the relationship that make the risk of sharing easier and less fraught with dangers. (1966, pp.185-86.)*

Three factors seem to have played a role in this evolution. First of all there was the study with schizophrenics which Rogers and his colleagues carried out between 1958 and 1964. With this very withdrawn group of patients, the 'classical' type of intervention - reflection of feelings - fell short: there was often very little to reflect. In their attempts at establishing contact, the client-centred therapists learned to use an alternative source of help, their own here-and-now feelings:

> *When the client offers no self-expression, the therapist's momentary experiencing is not empty. At every moment there occur a great many feelings and events in the therapist. Most of these concern the client and the present moment. The therapist need not wait passively till the client expresses something intimate or therapeutically relevant. Instead, he can draw on his own momentary experiencing and find there an ever-present reservoir from which he can draw, and with which he can initiate, deepen, and carry on therapeutic interaction even with an unmotivated, silent, or externalised person. (Gendlin, 1967, p.121.)*

There was, moreover, the contact with a number of existential therapists, such as Rollo May and Carl Whitaker, who criticised them for effacing themselves too much in the therapeutic relationship for standing too much behind the client as an alter ego and too little as a real other person with an own personal identity. Thus Whitaker gave the following comments on a number of excerpts from client-centred therapies with schizophrenics:

> *It is as though the two were existing in some kind of common microcosm or isolation chamber or like twins in utero. These interviews are intensely personal for both of these individuals but only the patient's life is under discussion. This is so distinct that one sometimes feels there is only one self present and that self is the patient. It is as though the therapist makes himself artificially miniature. Sometimes this is so dramatic that I almost feel he disappears. This is in specific contrast to our type of therapy in which both persons are present in a rather specific sense and the therapeutic process involves the overt interaction of the two individuals and the use of the experience of each of them for the patient's growth. (Rogers et al., 1967, p.517.)*

This 'willingness to be known' (Barrett-Lennard, 1962, p.5), which had gradually found its way into their individual therapy praxis, emerged even more forcefully (perhaps at times too forcefully) in the 'encounter movement' of the sixties and seventies (Rogers, 1970, pp.52-55). Group dynamics, with its emphasis on 'feedback in the here-and-now', was certainly not foreign to this. All these influences have made client-centred therapy into a more interactional one, with the therapist not only functioning as an alter ego, but also as an independent pole of interaction, who expresses, at times, to the client his own feeling about the situation. On account of this transparency, the process becomes more a dialogue an I-Thou encounter. (Buber and Rogers, 1957; Van Balen, 1990, pp.35-38.)

In such an authentic mutual encounter, there may be moments in which the therapist almost relinquishes his professional role and encounters the client in a very personal and profoundly human way. According to Yalom, such 'critical incidents' often become turning-points in therapy. He believes that they are seldom mentioned in the psychiatric literature out of shame, or out of fear of censorship; they are also seldom discussed with trainees because they do not fit the 'doctrine' or because one is afraid of exaggerations. Here are a couple of Yalom's many examples (1980, pp. 402-03):

A therapist met with a patient who during the course of therapy developed signs suggesting cancer. While she was awaiting the results of medical laboratory tests (which subsequently proved negative) he held her in his arms like a child while she sobbed and in her terror experienced a brief psychotic state.

For several sessions a patient had been abusing a therapist by attacking him personally and by questioning his professional skills. Finally the therapist exploded: 'I began pounding the desk with my fist and shouted, Dammit - look, why don't you just quit the verbal diarrhoea and let's get down to the business of trying to understand yourself, and stop beating on me? Whatever faults I have, and I do have a lot of them, have nothing to do with your problems. I'm a human being too, and today has been a bad day.'

Transference and Transparency

Working through of the transference is not thought of as a nuclear process, as the 'pure gold', in client-centred therapy. The therapeutic relationship is not structured in such a way as to maximise regression. We rather follow an orthopedagogic model, in which growth is stimulated right from the start, and the real relationship aspects are emphasised. John Shlien even goes as far as to say that transference is 'a fiction, invented and maintained by therapists, in order to protect themselves from the consequences of their own behaviour' (Shlien, 1987, p. 15). But, with the reviewers of his paper and with such authors as Pfeiffer (1987) and Van Balen (1984), we have to say - in my opinion - 'Yes, John, there is a transference.' Or as Gendlin has it:

If the client is a troubled person, he cannot possibly fail to rouse difficulties in another person who relates closely with him. He cannot possibly have his troubles all by himself while interacting closely with the therapist. Necessarily, the therapist will experience his own version of the difficulties, twists, and hang-ups which the interaction must have. And only if these do occur can the interaction move beyond them and be therapeutic for the client. (Gendlin, 1968, p.222.)

In client-centred therapy too, the client repeats his past in his relationship with the therapist. But the way it is dealt with is partly different from the psychoanalytic orientation. Firstly, there is the belief that certain transference reactions - which can be viewed as security measures on the part of the client - will gradually melt away without explicit working through under the beneficial effect of a good working alliance. Secondly, client-centred therapy does not provide a priority in principle to working with a problem in the here-and-now relationship with the therapist. The criterion for further exploration is, according to Rice, the vividness with which a certain type of problem is experienced, and not where this experience is located on the triangle here-elsewhere-in the past:

In a real sense, any member of a class is as worthwhile exploring as any other. Neither the past nor the present has priority, but rather the vividness with which an experience can be recounted by the client. After all, the more vividly an experience is recounted, the more likely it is to be an experience that is emotionally important to the client. More adequate processing of any one experience should lead to more adaptive responses in a whole range of specific situations. (1974, p.303.)

In Rice's view, therefore, the working through of transference reactions in the here-and-now of the therapeutic relationship is not a 'must' but a possibility, a sub-process along with other ones I personally feel that it is nevertheless an important sub-process which comes into prominence especially in the longer therapies. What is then the role of the therapist's transparency when transference reactions are worked through in client-centred therapy). Here are some thoughts.

The emphasis is not on working to achieve insight, which consists of recognising and genetically understanding how the client distorts the therapist and relates to him in a structure-bound way, but on the corrective emotional experience:

It isn't enough that the patient repeats with the therapist his maladjusted feelings and ways of setting up interpersonal situations. After all, the patient is said to repeat these with everyone in his life, and not only with the therapist. Thus, the sheer repeating, even when it is a concrete reliving, doesn't yet resolve anything. Somehow, with the therapist, the patient doesn't only repeat; he gets beyond the repeating. He doesn't only relive; he lives further, if he resolves problems experientially. (Gendlin, 1968, p.222.)

This living further' sometimes requires more than neutral benevolence (Wachtel, 1987). It requires the therapist not to present himself as a white screen but - apart from, and in addition to, his empathic interventions - to deal in a transparent way, at the right moment, with what lives in the interaction between

the two of them, and hereby to express his version of the interaction. Thus, the therapist may question the client's image of him by putting his own experience next to it. He may give the client feedback about his way of dealing with him and about the feelings he evokes in him. Where needed he makes his own limits explicitly known: indeed the client can 'discuss' anything; he cannot just do anything. In order to perform this interactional work properly, a therapist should pay special attention to what happens between him and his client, to the relationship aspect of the communication; and he should keep in touch with what the client 'does to him'. In Yalom's words, the here-and-now feelings are to the experienced therapist 'of as much use as a microscope is to the microbiologist' (1975, p.149). We also find this view in the humanistic branch of the Freudian analytic school where the 'countertransference' is not seen as a 'crack in the mirror', but as an aid in the analytic work (Corveleyn, 1989; Wachtel, 1987). Obviously we could find here a link with the interactional approach, as proposed by Kiesler (1982) as well as by van Kessel and van der Linden (1991).

Suggestions For Practice

What can a therapist reveal and what not? And at what moment can this best be done? Rogers dismisses this question - perhaps wisely - with the very general answer, '... when appropriate' (1962, p.417). Wachtel too, a psychoanalyst, writes in the same vein: 'I wish there were hard and fast rules about when exactly such self-revelations are helpful. Unfortunately, there are none... (1987, p.183). We are thus thrown back on our general clinical feeling and our common sense. This does not mean, however, that there are no guidelines. Indeed, there is the basic criterion which always goes back to the following question: does our self-revelation serve the client's growth process (Yalom, 1980, p.414)? Can our client use and integrate this information? In other words, we are talking here about a transparency with responsibility, and this includes right away the presence of important restrictions. As therapists, we have to withhold what does not help the client, and this is a lot. Yalom illustrates this basic principle with a touching story about two famous healers, taken from a book by Hermann Hesse.

> *Joseph, one of the healers, severely afflicted with feelings of worthlessness and self-doubt, sets off on a long journey to seek help from his rival, Dion. At an oasis Joseph describes his plight to a stranger, who turns out to be Dion; whereupon Joseph accepts Dijon's invitation to go home with him in the role of patient and servant. In time Joseph regains his former serenity, zest, and effectance and becomes the friend and colleague of his master. Only after many years have passed and Dion lies on his deathbed does he reveal to Joseph that when the latter encountered him at the oasis, he, Dion, had reached a similar impasse in his life and was en route to request Joseph's assistance. (Yalom 1975, p.215.)*

From this focus on the client's growth process it follows that the therapist will only exceptionally mention facts from his personal life. But 'exceptionally' does not mean 'never'. A therapist can thus, as said earlier, reveal something about himself as a way of showing empathy. Also, when a personal event in his life comes to weigh heavily on his therapeutic work (such as the death of an important person), it may be better to mention it. And what if the client asks us for our personal philosophy of life, our lifestyle or our values? Obviously, we should be very careful here and explore, with the client, the precise meaning of his question. In most cases the client is not really interested in the therapist, but such questions may be situated within the search for a solution to a personal problem, or within a specific relational context. Our attention should thus go in that direction. Client-centred therapists generally refrain from giving 'personal testimony', in my opinion for good reason: indeed, the client has to find his own way. But one thing does not always exclude another. We should not forget that clients often obtain indirect clues as to 'how we live our lives' and that we can never totally escape a modelling role. This is not wrong in itself, at least not if we can bring the client to becoming independent from it. If we succeed in this, the client gradually comes to see his therapist as 'a fellow pilgrim' (Yalom, 1980, p.407), with whom and against whom he can clarify his own choices. This happens mostly towards the end of therapy, i.e. in the existential phase (Swildens, 1988, p. S4), in which the client has reached the point where he can choose freely.

As will be clear from what I said before, self-revelation has seldom anything to do with the therapist's personal past or present life. But what can the therapist then reveal? The answer is obvious: his feelings towards the client in the here-and-now, towards what happens in the session between both of them. Here too, the therapist remains sober. Only 'persisting' feelings count, and besides, the therapist has to ask himself if the moment is appropriate. There is thus a problem of 'timing': is there a chance for the client to be sufficiently receptive to my feedback about how I experience the interaction, or should other therapeutic tasks take precedence? Sometimes the relationship has not yet acquired enough security and solidity, and this should be worked on first. In moments of great vulnerability, empathic closeness is perhaps all that is needed.

Sometimes, the client may first need a chance to fully express his feelings towards the symbolic figure of

the therapist, without immediately being 'stopped' by a confrontation with the 'reality' of how the therapist experiences it himself ... But occasionally, the therapist's experience of the interaction may be the most fruitful approach to deepening the process.

Besides the question of what can be said and when, we also should address the one about how to communicate our own experiences in the most constructive way. Here are some suggestions from the client-centred literature: Boukydis, 1979; Carkhuff and Berenson, 1977; Depestele, 1989, pp.63-69; Gendlin, 1967; Gendlin, 1968, pp.220-25; Kiesler, 1982; Rogers, 1970, pp.53-57. All illustrate how important it is that the therapist's self-expressive interventions be supported by the basic attitudes. The close bond with congruence is obvious: the feeling for what happens in the relationship, the interactional barometer, thus should function properly! This presupposes a close contact with one's own flow of experiencing and the meanings which it may contain, sufficient awareness of what may be one's personal contribution to the difficulties arising in the relationship, and when needed, sufficient openness to facing the issue in question (so it would not become a battle about who is right), being capable of communicating one's experience in a process-compatible way, i.e. in all its complexity and changingness. As an example of the latter, Rogers describes how a therapist can communicate 'boredom':

> *But my feeling exists in the context of a complex and changing flow, which also needs to be communicated. I would like to share with him my distress at feeling bored and my discomfort in expressing it. As I do, I find that my boredom arises from my sense of remoteness from him and that I would like to be in closer touch with him; and even as I try to express these feelings they change. I am certainly not bored as I await with eagerness, and perhaps a bit of apprehension, for his response. I also feel a new sensitivity to him now that I have shared this feeling which has been a barrier between us. I am far more able to hear the surprise, or perhaps the hurt, in his voice as he now finds himself speaking more genuinely because I have dared to be real with him. (1966, p.185.)*

Along with this, there is the link with unconditional positive regard. Self expressive confrontations are most effective when embedded in, and communicated out of, deep involvement with the person of the client. Consequently, it is important for the therapist not to let negative feelings accumulate for too long, so as to remain sufficiently open to the client. He further has to let it be known clearly that his feelings have to do with a specific behaviour of the client's, and not with the client as a person. Therefore, the therapist's feedback should be as explicit and concrete as possible: how the feeling took shape and what precisely in the client's way of interacting has brought it on. Perhaps most importantly, the therapist should remain focused on the positive life-tendencies behind the client's disturbing behaviour and behind his own negative feelings, and communicate these as well. Thus, in our earlier example, Rogers communicates the inside, the reason for his boredom, which is his desire for more contact with the client. When we give a client feedback about a behaviour which irritates us, we try to get in touch with the needs and positive intentions behind it, and include these in our discussion. Gendlin gives the following example of this pertaining to setting limits:

> *For example, I might not let a patient touch me or grab me. I will stop the patient, but in the same words and gesture I will try to respond positively to the positive desire for closeness or physical relations. I will make personal touch with my hand as I hold the patient away from me, contact the patient's eyes, and declare that I think the physical reaching out is positive and I welcome it, even though I cannot allow it. (I know at such times that I may be partly creating this positive aspect. Perhaps this reaching is more hostile, right now, than warm. But there is warmth and health in anyone's sexual or physical need, and I can recognise that as such.) (1967, p.397.)*

Finally, we should always take care in maintaining the process sufficiently client-centred and making it a 'self-revelation without imposition'. This can best be done by letting the influencing occur as openly as possible. Two 'rules of communication' should be remembered here. The first one, to use Rogers' words, is 'owning' or giving I-messages instead of you-messages: the therapist indicates clearly that he is the source of the experience and tries above all to communicate what he himself feels, rather than making evaluative statements about the client. He will, for example, not say 'How intrusive of you' but 'When you called me for the second time this week, I felt put under pressure and as if taken possession of ... The second rule of communication is, in Gendlin's words, 'always checking' or 'openness to what comes next': after each intervention - and especially after one which originated in our own frame of reference - tuning in anew to the client's experiential track and continuing from there. All these suggestions should make it clear that constructive self-revelation is far removed from acting-out. It is rather a form of 'disciplined spontaneity' which, along and together with empathy, constitutes a second line from which the client can evolve towards a 'further living' inside and outside of therapy, towards new and more satisfactory ways of dealing with himself and others. Mistakes may, of course, occur if self-revelation is used rather carelessly, but to

leave out this important reservoir of relationship information could be equally detrimental: an omission which could lead to substantial reduction in quality of the therapeutic process.

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