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# Phenomenological and humanistic approaches

## ◆ Introduction

The attitude enshrined in humanism is essentially positive: it identifies and upholds the basic goodness of each individual, while at the same time recognising the adverse circumstances that may obscure these qualities at various stages throughout life. This is in sharp contrast to the theory of personality described by Freud, which stresses drives, instincts, impulses and urges as motivating factors in human behaviour. In Freudian terms, people are governed by powerful forces originating in the unconscious, and it is those forces which compel them to act in certain ways.

Both Adler and Jung moved away from this deterministic position and, in doing so, highlighted other aspects of experience they felt could explain human development and behaviour. In Jung's paradigm, however, unconscious forces are still very much in evidence, although his overall view of people is more extensive, with a focus on adult dilemmas not found in Freudian theory.

The work of the ego psychologists indicates another fairly radical shift of emphasis, with their focus on thinking and other cognitive processes they believed to be present at an early stage of life.

In this and the next unit we shall discuss those models of counselling which have been directly influenced by phenomenology and humanism; we shall also consider the concepts and skills integral to each theoretical approach. The following theories and counselling models are dealt with in this unit:

- Rogers and the person-centred approach
- Maslow and humanism
- the existential approach.

## The meaning of phenomenology in relation to counselling

The word 'phenomenology' stems from philosophy and refers to the way in which individuals perceive and interpret events. Another way of stating this is to say that it is not the actual events that cause people to behave in certain ways; instead, it is each person's unique perception of those events which determines their responses. The recognition that each individual is influenced by his or her own phenomenal field is important in the counselling context, since it underlines the need to discover clients' individual perceptions if we are to be effective in helping them. It is not enough for counsellors to simply

assume that clients will respond in specific ways to certain situations or events. On the contrary, counsellors need to be aware of the vast spectrum of individual difference that has to be taken into consideration in relation to the experiences clients describe. The following example gives some idea of the way in which two people, who appear to have exactly the same experience, record entirely different perceptions of it.

## CASE STUDY

### Recalling an accident

A client called Rosaleen came into counselling because she had been in a car accident and had suffered post-traumatic shock as a result of it. Her sister had also been in the accident, and though neither of them sustained physical injury, both had taken time off work in order to recover. The difference between the two sisters' responses lay in the fact that whereas Rosaleen felt immensely traumatised by it, her sister seemed relatively unaffected by events, although she did concede that it had been frightening initially. Rosaleen's sister took some time off work on the advice of her doctor, but she was anxious to get back to the office just as soon as she could. The resilience of her sister caused some difficulty for Rosaleen, because it made her feel guilty about her own response. She discussed her feelings with the counsellor.

**CLIENT:** I worry that people might think I'm putting it on. Jean [her sister] never seemed to look back. I'm sure people must think it's all in my mind.

**COUNSELLOR:** That's obviously something that concerns you a great deal . . . the idea that people will think badly of you.

**CLIENT:** Well yes . . . Because of the way she is. There is such a contrast in our reactions.

**COUNSELLOR:** Yet people do react in very different ways . . . to a whole lot of situations.

**CLIENT:** People can't be the same in the way they see things . . . I suppose I'm . . . maybe weaker in some ways. But it's hard to believe we were both in the same car.

**COUNSELLOR:** With a different experience of the accident . . .

**CLIENT:** Yes, and different reactions, too.

**COUNSELLOR:** In the way that people tend to respond quite differently to things.

**Comment:** The counsellor who worked with Rosaleen was concerned to help her explore all the circumstances of the accident. She also wanted to show the client that her individual response to the accident was a perfectly valid one, even though it differed from her sister's response. To do this the counsellor listened carefully to the client's story, and encouraged her to voice all the worries she felt in relation to

**CASE STUDY Cont...**

other people's views. It might have been tempting for the counsellor to reassure the client that she was not, in fact, weaker than her sister, but such reassurance would have been misplaced. From a purely person-centred perspective, it is important to remember that clients' feelings are real to them, and the counsellor's task is to stay within the client's internal frame of reference – a concept we shall discuss later in this unit.

However, several other points are significant in relation to this client's experience and the counselling she received. The first point concerns the two quite different responses to the car accident, a difference that can be explained in various ways. In the first place, no two people are ever entirely the same, even when they are sisters. In the second place, Rosaleen's life experience just prior to the accident was very different from her sister's. It emerged in the course of counselling that the client had recently been ill with glandular fever, a fact that compounded the trauma of the accident. Rosaleen's relationship with her parents was different too. She had never felt as close to them as her sister seemed to be, and just before the car accident she had argued with her father. All these factors combined to influence the client's unique response to the accident, but once she identified them she felt less guilty about any differences in relation to her sister.

**KEY TERM**

**Person-centred:** This refers to an attitude which counsellors, or ideally any person in the helping professions, should have. It means paying attention to the real person of the client and identifying their individual experiences and needs, which are quite separate from anyone else's.

## Rogers and the person-centred approach

Carl Rogers (1902–1987) is the psychologist whose name is synonymous with the person-centred approach to counselling. Rogers, who was born in Illinois, studied theology, but later switched to psychology and received his Ph.D. in 1931. During this time he worked at a child guidance clinic in New York, and published *The Clinical Treatment of the Problem Child* in 1939. After this, he was invited to become a member of the Psychology department at Ohio State University. However, it was not until 1945 that Rogers' counselling theory and practice began to make an impact. Throughout his academic career he also gained a great deal of experience as a therapist and continued to write books, including *Client-Centred Therapy* (1951) and *On*

*Becoming a Person* (1961). The emphasis in all of Rogers' later writing is on the importance of each person as the architect of their individual destiny. Rogers firmly believed that everyone has sufficient innate resources to deal effectively with life and the various problems living entails. These innate resources are, according to the person-centred approach, sometimes obscured, forgotten or even denied, but they are, nevertheless, always present with the potential for development and growth (Rogers, 1951). The impact of Rogers' work is best understood when we contrast it with the world of therapy that had existed before he contributed to it. Freudian theory and practice was in the ascendant, especially in America where many prominent psychoanalysts had been forced to emigrate from Europe. The other major influence that had dominated North American psychology was the behaviourist school (which we shall discuss in a later unit), with its emphasis on learned behaviour as the basis of human personality development. Against the background of these major influences, Rogers' insistence on the uniqueness of the individual, and the individual's innate tendency towards growth and wholeness, certainly seemed to represent a much more optimistic and positive viewpoint.

## Rogers' concept of 'self'

Rogers believed that people will, if given the right conditions and opportunities, move towards autonomy and self-direction (Rogers, 1961). The concept of 'self' is important here, and refers to the 'I' or the 'me' part of each person. According to Rogers, personality development can be viewed in terms of self-concept development, which, in turn, depends on the individual's interaction with other people and the environment. Rogers did not describe stages or phases of development in the way that Freud, Klein or Erikson did, for example. Instead, he concentrated on the individual's perception of self, as well as the ways in which these perceptions are coloured by other people's evaluations and expectations. From a very early age, children seek to please their parents or carers who are, after all, the most important people in the world to them. Each person's self-concept is acquired in this way and is continually reinforced throughout life, as a result of ongoing interaction with others. The small child sees him or herself reflected in the attitudes expressed by parents and other important people. When very little love and a great deal of criticism are received, a negative self-concept is bound to follow.

## The real or organismic self

No matter how traumatic or negative the environment, however, there remains within each person a core or inner self, which is never entirely obliterated. Each person's innate tendency towards growth is always present and, with the right conditions, will emerge and flourish. Clients in counselling often refer to their 'real' selves; they often do so with regret and sadness, especially when they have never before been given the opportunity to identify and express their authentic needs and feelings. The following client had such an experience.

## CASE STUDY

### Identification of needs

A 65-year-old woman received counselling while in hospital suffering from cancer. She talked to a nurse who was specially trained to help people in her position. During their exchanges she referred to her early years as a mother bringing up a large family.

**MRS COOPER:** I did most of it without too much thought . . . I certainly didn't have much time to think about myself!

**NURSE:** You were just too busy attending to everyone else . . .

**MRS COOPER:** It's a funny thing [pause] . . . when I was younger . . . As a child, I didn't get time to think of myself either. It probably sounds like self-pity, but it's only now that I'm ill . . . that I've thought about it seriously.

**NURSE:** So it feels like self-pity because you've never had anyone else ask you or seem interested before.

**MRS COOPER:** That's it. I even feel guilty talking to you . . . that I might be wasting your time.

**NURSE:** You are not wasting my time. I am interested in what you say, and it's your time too.

**MRS COOPER:** Well I would . . . [hesitates] I would like to start some studies . . . if it's not too late.

**NURSE:** It's not too late to do that. Maybe we could talk about what it is you would like to do?

**MRS COOPER:** Well when I was in my teens, I loved poetry and literature . . . Then I just got away from all that . . . and then marriage and the family intervened [laughs]. The thing is, my husband will think I've gone crackers.

**NURSE:** But you don't think you're crackers.

**MRS COOPER:** No.

**NURSE:** So now, you're really sure of what you really want to do, and that's a very important start.

**MRS COOPER:** It is, I don't think I would be happy at this late stage . . . if I didn't try to do something for myself . . . for the real me.

It is often very difficult for people to identify the real self. Many people go through life convinced that the outer self, or self-concept, is the only reality they have. It sometimes takes a crisis to highlight the 'falseness' of the image someone presents to the world. At times like this, a person may finally get

in touch with the feelings, needs and ambitions that had previously been obscured. The fact that people do frequently alter their lifestyles in the wake of a crisis illustrates this last point. Clients also come into counselling in the aftermath of a crisis, or indeed even in the middle of one. At such times, they often sense some intimation of disquiet or regret that prompts them to pursue the idea of change. When there is a vast difference between a person's self-concept and the real self, problems of identity will certainly arise at some stage of life.

The case study (identification of needs) highlights another important point, which is that elderly people are rarely given sufficient opportunity to talk about their unique life experiences. In Mrs Cooper's case, it was different because she was diagnosed with cancer and being cared for by a specialist nurse, who was trained to listen to her. In her book *Growing Old: A Journey of Self-Discovery*, Danielle Quinodoz explains that in her work as a psychoanalyst she had often observed elderly people who were surprised to discover that they had lived their lives as if the script had been written by someone else. She then points out that these clients still had time to change things, to make the 'imaginative leap' so that their experiences became their own and 'nobody else's' (Quinodoz, 2010: 131). To achieve this, however, elderly clients need to be heard, so that they can identify the 'real self' as distinct from the 'outer self', which they may have presented to the world over a very long period of time. Person-centred counselling can facilitate this change of focus, a change that is possible regardless of how old a person actually is.

### KEY TERM

**Organismic self:** The real inner life of the person which is present from birth and gravitates towards self-actualisation, integration and harmony.

## The actualising tendency

The term 'self actualisation' is one Rogers (1951) uses to describe the human urge to grow, to develop and to reach maximum potential (Rogers, 1951: 488). The actualising tendency is responsible for every aspect of human endeavour and achievement. In some ways it resembles the Freudian concept of libido or life force. The actualising tendency is present from birth onwards and is not just concerned with achievement in a narrow sense. On the contrary, it has a much broader meaning and describes the holistic development of all aspects of the person, including the spiritual, emotional, physical and creative dimensions. The concept of the actualising tendency is important in the counselling context, since it underlines the idea that clients have the necessary resources for dealing effectively with their own problems. If counsellors truly believe this, they are likely to value and respect the

people they help. It is sometimes the case that a client's actualising tendency is, for whatever reason, temporarily stultified. But when the right conditions are present in counselling there is a strong possibility that the client's inner resources will be located.

## KEY TERMS

**Actualising tendency:** A propensity described by both Rogers and Maslow. It refers to the human urge to grow, develop and reach maximum potential.

**Self-concept:** This is a person's view of self which is acquired in early childhood, and developed through life experience. It is reinforced by the reflected appraisals of other people, especially parents, and other important figures in a person's life.

## The core conditions

Rogers identified certain core conditions he believed to be necessary if clients are to make progress in counselling. These conditions really describe counsellor qualities and attitudes, which, if present, will facilitate change and growth within the client. Among the most important of these attitudes is the counsellor's ability to understand the client's feelings. Another is respect for the client, while a third is described as counsellor congruence or genuineness. In summary then, the Rogerian core conditions are as follows:

- empathy
- unconditional positive regard
- congruence or genuineness.

(Rogers, 1957: 95–103)

## Empathy

The word 'empathy' describes the counsellor's ability to understand the client at a deep level. This is, of course, much easier said than done, since it involves awareness of what it is the client is actually experiencing. Earlier in this unit we discussed the word 'phenomenology' and looked at the different ways in which people experience reality. Rogers refers to the 'internal frame of reference' to denote the client's unique experience of personal problems (Rogers, 1951: 29). The task for the counsellor is to get inside the client's frame of reference. If this is not achieved, then no real point of contact is made between counsellor and client.

Rogers further uses the term 'external frame of reference' to describe this lack of understanding and contact (Rogers, 1951:47). When a counsellor perceives the client from an external frame of reference, there is little chance that the client's view will be clearly heard. It is important for clients (if they are to benefit from counselling) to sense that their individual experience of 'self' and reality is appreciated by the helper. However, this does not mean that

counsellors should experience the emotions a client experiences. In fact, it would be counter-productive for the counsellor to become emotionally involved in this way; it would certainly upset the balance of the relationship between client and counsellor. In order to stay within the client's internal frame of reference, it is necessary for the counsellor to listen carefully to what is being conveyed (both verbally and non-verbally) at every stage of counselling. The counsellor needs to imagine and appreciate what it is actually like to be the client, and this appreciation of the client's experience then needs to be conveyed to him or her.

## EXERCISE

### Sympathy and empathy

In groups of three to four, discuss the words 'sympathy' and 'empathy' and say what you think the differences are between them. Are there any circumstances (outside counselling) when it may be appropriate to use sympathy? What skills are necessary in order to convey empathy to clients?

## EXERCISE

### My own thoughts and feelings

To develop awareness of other people's feelings, we must first become aware of our own. One way of tuning into our own feelings is to set aside some time each day to listen to ourselves. Start now by spending ten minutes in silence. Identify your thoughts and feelings during this time, and then write them down. It doesn't matter how mundane or banal these feelings and thoughts may be; they are all relevant to the exercise. The point here is to gain practice in becoming more self-aware and ultimately more aware of others in the process.

## EXERCISE

### Identifying feelings

We often express our feelings inaccurately by using vague or general terms, rather than words that express specific emotions. For example, we may say we feel 'let down' when someone fails to turn up, when we really mean that we feel rejected. In order to develop true awareness of feelings, it helps to make lists of 'feeling' words that express emotions more precisely.

Working individually, make lists of all the words that express the following:

- ◆ grief
- ◆ disappointment
- ◆ sadness
- ◆ happiness
- ◆ sorrow
- ◆ excitement
- ◆ relief
- ◆ embarrassment.

## Unconditional positive regard

The need for positive regard is present in all human beings from infancy onwards. This need is so imperative that small children will do almost anything in order to achieve it. People need love, acceptance, respect and warmth from others, but unfortunately these attitudes and feelings are often only given conditionally. Parents may say, or imply, that their love is given on condition that certain criteria are met. When this happens it is impossible for children to feel valued for themselves alone. Many people who come into counselling have experienced such parental attitudes, which are often reinforced throughout life. Rogers believed that counsellors should convey unconditional positive regard or warmth towards clients if they are to feel understood and accepted. This means that clients are valued without any conditions attached, even when they experience themselves as negative, bad, frightened or abnormal (Rogers, 1996).

Acceptance implies a non-judgmental approach by counselors; it also means caring in a non-possessive way. Rogers refers to a counsellor attitude of positive regard, which clearly acknowledges the client as a separate person, one who is entitled to his or her own feelings and experiences (Rogers, 1996). When attitudes of warmth and acceptance are present in counselling, clients are likely to accept themselves and become more confident in their own abilities to cope. However, acceptance of clients does not mean that counsellors must like or approve of everything they do. What is important is that counsellors are able to separate their own views from those of clients. The values and views held by clients may differ quite dramatically from those held by individual counselors. But even in these circumstances, clients deserve (and should receive) respect and positive regard from the people in whom they confide.

### EXERCISE

#### Conveying warmth

Working individually, think of a time in your life when you received warmth and positive regard from someone who helped you. How did this person convey these attitudes to you? What were the circumstances in which you needed help? How did these attitudes help you at the time?

## Congruence or genuineness

The words ‘congruence’ and ‘genuineness’ describe another quality which Rogers believed counsellors should possess. This quality is one of sincerity, authenticity and honesty within the counselling relationship. In order to be congruent with clients, counsellors need to be themselves, without any pretence or façade (Rogers, 1996). This means, of course, that counsellors need to know themselves first. In the absence of self-knowledge, it would be

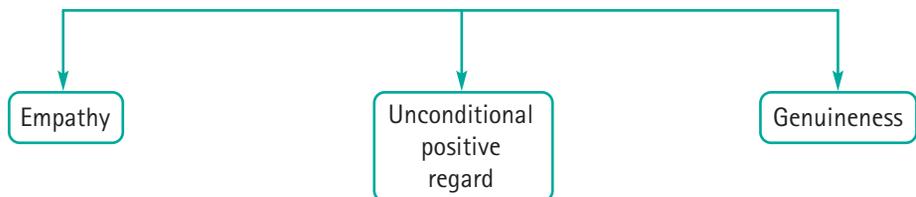
totally impossible to develop attitudes of openness and honesty in relation to clients. Honesty and openness do not imply uninhibited frankness; however, when empathy and positive respect are also present in the relationship, uninhibited frankness is unlikely to be a problem. A very important aspect of counsellor genuineness is that it acts as a model for those clients who may find it difficult to be open and genuine themselves. Appropriate and genuine responses to clients are always prompted by real concern for them. The following exchange between counsellor and client illustrates this point.

## CASE STUDY

### Being open

- CLIENT:** My boyfriend has been really nasty at times . . . Sometimes, well last week he did go over the top and lashed out.
- COUNSELLOR:** He hit you . . .
- CLIENT:** Well maybe I asked for it [smiles] . . . we both have tempers. He's OK really.
- COUNSELLOR:** I'm a bit puzzled by what you've just said . . . and the way you said it. You smiled when you mentioned that he hit you.
- CLIENT:** It's just that I don't want to make too much of it . . . or blame him for everything.
- COUNSELLOR:** But still the situation makes you tense and nervous?
- CLIENT:** It does. I want to understand it . . . him I mean. He wasn't always like that. He used to be so kind to me [starts to cry].

**Comment:** During this exchange with the client, the counsellor identified what she regarded as a discrepancy between what the client said and the way that she said it. The counsellor was confused by this discrepancy so she referred to it, in order to clarify things for herself. However, she was also concerned to encourage the client to look more closely at her own feelings, including those feelings she had expressed and those which were unexpressed. Being open with the client was the counsellor's way of indicating that she wanted to understand her more fully. This openness also helped the client to understand herself at a deeper level.



**Figure 5.1** Rogers' core conditions

## The counselling relationship

We have already seen that the person-centred counselling relationship is based on respect for the client, the establishment of an empathic bond and a willingness on the counsellor's part to be open and genuine with the client. In addition to these qualities, however, there is also an emphasis on facilitating each client's growth or self-actualisation. It is only when the core conditions, described above, are present in the relationship that self-actualisation can be achieved. The counselling skills discussed at the beginning of this book are used in the person-centred approach and are necessary for the development of a therapeutic relationship between counsellor and client. These skills include:

- active listening
- responding to clients through reflection of feeling and content
- paraphrasing and summarising
- asking open questions
- responding appropriately to silence and client non-verbal communication.

Helpers who are interested in the person-centred approach must be prepared to encounter clients on a basis of equality and to work with them in a non-directive way. In many respects, the person-centred approach is characterised more by what the counsellor does not do, rather than what he or she does. Offering psychodynamic-style interpretation, for example, is avoided and the main focus of therapy is on clarification of the client's feelings so that identification of the 'real' self is facilitated. In conclusion, the essence of person-centred counselling lies in the attitudes and values of the helper and this, of course, necessitates proper training and adequate supervision for those counsellors who wish to use it.

## Transference

Although the possibility of transference reactions is acknowledged in the person-centred approach, these reactions are never highlighted or encouraged by the counsellor. A basic aim of the model is to help clients achieve independence and autonomy, so the projection of dependent feelings on to the counsellor would be viewed as a hindrance to this. The attitude of the counsellor to the client should indicate acceptance and equality from the outset and this, in turn, will lessen the possibility that transference reactions are sustained. Rogers does concede that transference attitudes do exist 'in varying degrees' in clients who undertake person-centred therapy (Rogers, 1951: 200). He specifically refers to clients who may be dependent, or expect to be dependent, and to clients who may fear the therapist as an authority figure. Of course, these fears are likely to be a reflection of apprehension towards all authority figures, especially parents. However, Rogers goes on to point out that it is what happens to these clients' expectations that matters. In Freudian psychoanalysis, transference attitudes tended to develop into an intense

emotional relationship, whereas in the person-centred approach this is unlikely to happen because of the basic equality of the relationship (Rogers, 1951).

It should be added that unconscious motivation is also acknowledged in the person-centred approach, but counsellors do not focus specifically on it, nor do they usually ask clients to work with dreams. Since the model is person-centred, however, clients who wish to look at dreams or the unconscious are at liberty to do so. In a similar way, counsellors accept and understand any transference feelings expressed by clients towards them. It is this very acceptance of the client's experience that tends to foster equality in the relationship.

## Clients who benefit from this approach

The person-centred approach has wide application within the helping professions, the voluntary sector, human relations training, groupwork, education and institutional settings, where the goals are to foster good interpersonal skills and respect for others. This last group would include, among others, churches, businesses, youth organisations and crisis centres. In the context of therapy and counselling, the person-centred approach is suitable for use with clients in the first stages of crisis. Later on, however, clients in crisis may need a more directive approach to help them cope with the practical and long-term aspects of their problems.

From a feminist viewpoint, person-centred counselling has significant advantages over some of the other models. This is because it encourages clients to consider and identify their own feelings and needs, something which many women (especially those who have spent a lifetime caring for others) may never have been able to do before. Clients who have been bereaved should also benefit from the person-centred approach, since one of the things bereaved people appear to need most of all is validation of their individual responses to loss. However, as Cooper (2008: 45) indicates, counselling for bereavement has become 'controversial' in recent years. Grieving is certainly a natural process that cannot be 'cured' by counselling, regardless of the theoretical approach being used. When grief is complicated though, many clients do seek counselling and benefit from it. If the core conditions Rogers describes are present in counselling, clients are more likely to explore any difficulties that impede their ability to cope with loss. People with relationship difficulties should also derive some advantage from working with a counsellor who gives them respect, understanding and openness, which they may not have experienced in everyday life.

The principles of the person-centred approach have been applied to a variety of therapeutic situations including marriage counselling and family therapy. Many support groups work by extending the core conditions to its members. Alcoholics Anonymous is a case in point and is a good example of the therapeutic effects of respect, understanding and openness for people

who want to change. Telephone counselling is another therapeutic medium through which Rogerian attitudes can be extended to clients, especially to those who are in deep distress or crisis.

Perhaps one of the greatest strengths of the person-centred approach is that it is often the training of choice for health professionals and others who are affiliated to hospitals, health centres and other organisations where people work together to help clients and patients. However, other models can be used in these settings too.

## The person-centred approach in other contexts

The person-centred approach to counselling is suitable for use with elderly clients, a group whose needs are often diverse and sometimes overlooked. It is worth elaborating on the needs of this particular client group. We know that old age is associated with many real or potential problems and that elderly people face possible deterioration in physical, as well as psychological, health. In their research paper 'Building Bridges: Person-Centred Therapy with Older Adults' (2012), Humboldt and Leal enumerate some of the problems that may beset people as they grow older. They include declining physical health, loss of independence, loneliness, depression, bereavement issues, disability, feelings of worthlessness and regret for past failures. In an approach to helping elderly clients, Humboldt and Leal highlight the Rogerian concept of empathy, and emphasise its effectiveness in interpersonal communication with older adults. When the core condition of empathy is used by helpers, older clients are more likely to feel understood; this is especially true when they have been bereaved or have experienced other losses. Humboldt and Leal also stress the importance of helpers (including therapists) to free themselves from any ageist stereotypes they might have about older people. These ageist stereotypes and negative attitudes are prevalent in society as a whole, so it is not far fetched to speculate that they could affect (at least unconsciously) those within the helping professions too. A more thoughtful approach to supporting the elderly to live fuller and more meaningful lives is an objective to which we should all subscribe. Use of Rogers' core conditions of empathy, unconditional positive regard and genuineness would certainly go a long way towards helping us to see older people and their individual needs more clearly. Another important point to make here is that when older people are helped to identify and express their real needs, they tend to become more confident as a result. This, in turn, leads to a greater capacity for self-help and willingness to access sources of support in a more confident manner.

## Experiences of older carers

There is a particular group of older people whose needs have, until fairly recently, been almost entirely ignored. In 2011, the Princess Royal Trust for Carers published the results of a survey, which indicated that people near, or over, retirement age undertook a high proportion of caring. This commitment to caring comes at a time when retired people would normally expect to wind down, or perhaps spend more time with grandchildren. The idea of pursuing leisure activities or enjoying retirement is not an option for older people who find themselves cast in a caring role, a responsibility which frequently arises when carers themselves are in poor or declining health. The person being cared for is often a spouse or partner, which means that the relationship itself is fundamentally altered. This change is likely to produce stress, which has the potential to exacerbate any health problems a carer may already have. The survey carried out by The Princess Royal Trust for Carers and entitled *Always on Call, Always Concerned* lists a number of key findings. These include the fact that two-thirds of older carers have health problems or a disability. Because of the demands of looking after another person, many carers cancel their own medical appointments, or abandon planned operations or procedures. Many carers never get a break or a holiday and many have financial problems and worry about the future. The report makes a number of recommendations, including the importance of training in carer awareness for health and social care professionals. In addition, it suggests that 'effective methods of promoting mental wellbeing' should be developed for older carers so that the risk of depression is minimised, or treated if already present (2011: 18–22).

Although there are a number of carers' support groups in existence, it is often the case that carers cannot get the time, or opportunity, to attend these. Individual counselling sessions are probably equally inaccessible when the demands of caring take precedence. One way of supporting older carers, however, is by concentrating on training for health and social care professionals as the report suggests. A person-centred approach to training, where the core conditions of empathy, positive regard and congruence are highlighted, is one way of helping professionals to develop the skills necessary to communicate effectively with carers. Many carers feel frustrated when they are not consulted by professionals, or when they are not involved as full partners in care. This deficit in communication means that carers do not feel heard, or understood, and their confidence is undermined as a result. There are numerous areas in which the difficulties experienced by carers could be ameliorated; but better communication through a person-centred approach to their needs is surely the most important one to address.

## Person-centred care and nursing

Training in person-centred communication skills would help health and social care professionals to relate more effectively to the people they care

for. However, this is not an entirely new idea. Several writers including McCormac and McCance (2010) have described its theory and practice. As far back as 2006, Innes et al. conducted an investigation into the role of health and social care workers delivering person-centred care to older people, disabled people and people from minority groups. They highlight (among other findings) the importance of overcoming bureaucratic obstacles before implementing person-centred care (Innes et al., 2006).

In 'Person-centred care: Principle of Nursing Practice D' (2011), Manley et al. discuss the person-centred approach to caring and make the point that organisations and health care teams often subscribe to the ideal of person-centred caring. However, actually delivering the philosophy is more challenging, since it requires 'specific knowledge, skills and ways of working', as well as organisational support and a culture that is accepted throughout the workplace (Manley et al. 2011: 35). The writers enumerate those nursing situations which are particularly problematic because of the transient nature of contact between patient and health care worker. These include, for example, nurses who work in theatre, where the skill of making rapid rapport with patients is essential. On the other hand, rapid rapport is not inconsistent with person-centred caring, and Manley et al. are clear about this. They discuss the ways in which a person-centred philosophy can be beneficial to patients and nursing staff. These include an emphasis on compassion, dignity and respect for human rights. In particular, they stress a need for greater understanding of the experiences of minority groups, their communication and cultural styles, and their perceptions of personalised care. A person-centred approach in nursing would also ensure that patient needs and aspirations are identified, patients are helped to make informed choices and shared decision-making between patients and staff is facilitated. Providing information to patients so that they understand procedures and technical information and supporting them in their own choices are also key elements discussed by Manley et al. (2011).

In order to establish good relationships with patients, nursing staff need to have self-awareness and good interpersonal skills to begin with. Training for staff is of vital importance, therefore, and not just at ward level but throughout the hospital system. Person-centred values need to be modelled by clinical leadership so that junior staff feel valued too. In all the criticism recently levelled against nurses and the nursing profession generally, this point is seldom made. It is difficult to see how nurses can embrace person-centred caring for patients, if they themselves feel undervalued.

Carl Rogers, who founded the person-centred approach, described it in the title of his book as *A Way of Being*, by which he meant that it is not just a method of communicating reserved for special occasions (Rogers, 1980). Rather, it is a psychological mindset, which we can all learn to develop in our relationships with other people. Such a mindset includes sincerely felt attitudes of acceptance and respect for everyone, including clients in counselling, patients in hospital, carers at home and vulnerable elderly people in residential care.

## Some limitations

Person-centred counselling is an approach that is suitable for most clients, though some with deeply repressed traumas and conflicts may benefit from a more psychodynamic perspective. However, the core conditions Rogers described would certainly work effectively if combined with appropriate skills from the psychodynamic model. People with depression, addiction, phobias or eating disorders are also likely to derive more help from other models, and some of these will be discussed in later units. Clients with alcohol problems may need more support than can be offered through individual counselling. Even when the core conditions are present in a one-to-one therapeutic situation, they may not be enough to sustain change for clients with some addictive problems. Another important factor to remember here is that deeply distressed and addicted clients (providing they are committed to change) may respond more positively in the presence of others with similar problems. Clients with repetitive thoughts and obsessions will probably gain more from a cognitive behavioural approach to counselling; there is no doubt that certain clients benefit from a more directive and structured approach generally. Cultural difference can also influence the way clients perceive those who help them; person-centred counsellors may sometimes be seen as passive, or lacking in initiative, by people who value advice or other more directive forms of intervention.

### EXERCISE

#### The core conditions

Working in pairs, look at the following relationships. How could Rogers' core conditions facilitate the work of the helper or manager in each case? Discuss a range of issues that may crop up in these relationships.

- ◆ nurse–patient
- ◆ doctor–patient
- ◆ lecturer–student
- ◆ social worker–client
- ◆ priest–parishioner
- ◆ manager–worker
- ◆ mother–child
- ◆ health visitor–new mother
- ◆ elderly resident–care assistant
- ◆ youth worker–teenager.

# Maslow and humanism

Implicit in Carl Rogers' person-centred theory is the idea that people have free choice and the ability to exercise control over their destinies. This is essentially an optimistic view of human nature, since the emphasis is on each person's creativity and strengths, rather than on weaknesses or failings. Such ideas are common currency in phenomenology and humanism, and it is this latter concept that has come to be associated with the work of Abraham Maslow.

Maslow (1908–1970) was born in Brooklyn, New York, where, as the only Jewish boy in the neighbourhood, he had a difficult and lonely childhood. His parents were keen that he should become a lawyer, but Maslow studied psychology instead and obtained his Ph.D. in 1934 from the University of Wisconsin. Maslow's first interest was in behavioural psychology, but over a period of time he became dissatisfied with this approach since it did not, in his view, adequately explain what it is that motivates people and gives meaning and purpose to human life.

Although he did acknowledge the existence of evil and destructiveness in the world, Maslow's primary focus of interest was in the more positive aspects of human experience. His views about aggression and hostility in children clearly show him as an advocate of humanism, since he highlights the fact that although children have been represented in a negative way throughout the history of psychoanalysis and psychology, there is a remarkable lack of scientific evidence to support this view (Maslow, 1970). Maslow refers to the selfishness and innate destructiveness of which children have been accused, and proposes instead that other, more positive, qualities are just as evident, especially in those children who are loved and respected by parents. This last point is important, because it stresses the central role of parents in the child's psychological development.

In addition to this, Maslow's focus on the formative influence of parents and on the need for positive emotional experiences in childhood links his ideas to those of several other theorists, whose work we have already considered. Relationships, and the need to be valued by others, is a central theme of Maslow's work; in this respect, it echoes the approaches described by Adler, the ego psychologists and, of course, the work of the object relationists. Although Maslow did not set up his own specific school of therapy or counselling, his influence on all contemporary approaches is considerable. In addition to this, he was certainly interested in ideas connected with therapy generally, and he was concerned to offer his own views about the helping process and the factors which facilitate or hinder it. The following is an outline of some of the contributions Maslow has made to our understanding of human motivation, personality and the nature of the helping relationship:

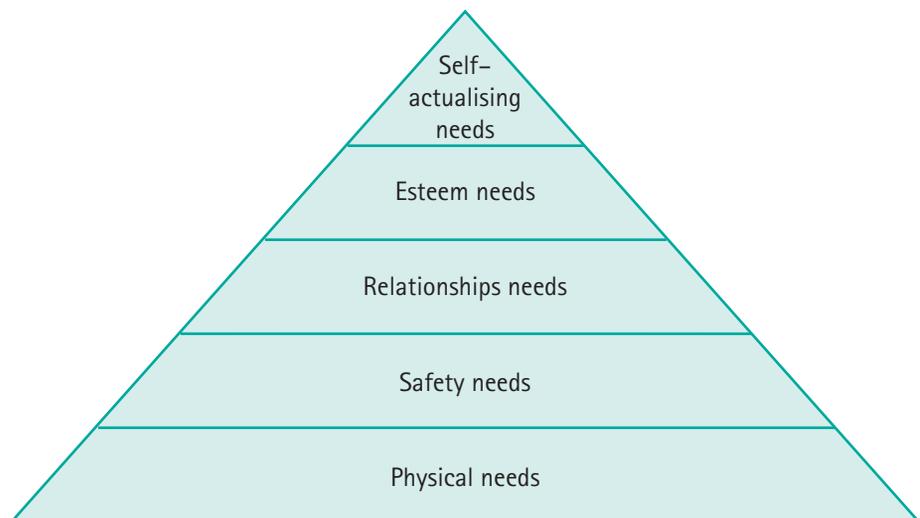
- the hierarchy of needs
- self-actualisation

- self-actualising people
- psychotherapy and other helping relationships.

(Maslow, 1970)

## The hierarchy of needs

Maslow formulated a theory of human motivation and outlined a series of innate needs, which, he believed, gave purpose, satisfaction and meaning to life. These are arranged in a hierarchy and include physiological, safety, relationship, esteem and finally self-actualisation needs (see Figure 5.2). Obviously, those needs which are lowest in the hierarchy (hunger, thirst, and so on) must be satisfied before any of the higher needs can be pursued. People living in circumstances of extreme poverty and privation, for example in certain third world countries, are unlikely to be concerned about self-actualisation needs when they are preoccupied with basic survival instead. This is not to say that people in these situations do not have the higher order needs that Maslow refers to. Indeed, their self-actualisation needs may simply take a different form. To produce healthy children and to live on through one's family is one example of a self-actualisation variant, which might well be applicable to different cultural groups. Maslow was, however, concerned to describe what he perceived to be the needs of people in America and other western cultures. In any case, the point he wished to make was that satisfaction of basic needs is generally important if people are to be motivated to achieve those higher up.



**Figure 5.2** Maslow's hierarchy of needs  
(Maslow, 1970: 15–45)

**EXERCISE****Needs**

Working in groups of two or three, discuss Maslow's hierarchy and say how you think a deficit in any of these needs could affect others in the hierarchy. What are the possible effects on those children whose safety and relationship needs are neglected, for example? How do neglected relationship needs affect an individual's chances of achieving full potential, educationally or otherwise?

**Self-actualisation**

A significant point of difference between the work of Maslow and most of the other theorists we have discussed in this book (apart from Rogers) concerns the emphasis Maslow places on psychological health and wellbeing. Many of the others, including Freud, were preoccupied with illness or pathology. This switch of attention from illness to health is evident in Maslow's concept of self-actualisation. A truly healthy person is one who is capable of developing innate talents and achieving maximum potential. In Maslow's opinion, it is impossible to understand human motivation if we look at it purely from a psychotherapist's viewpoint (Maslow, 1970). Any motivational theory, he believed, must consider the ultimate potential of healthy people, as well as looking at the problems and neurosis of those who are ill or debilitated. True understanding of human development and motivation is only achieved through a more comprehensive and holistic appraisal of humanity generally.

These ideas, expressed by Maslow, are similar to those articulated by Rogers and, indeed, the self-actualisation concept is common to both of them. This is not surprising, since both men worked together and, in 1962, helped to found the Association for Humanistic Psychology, along with other colleagues (including Rollo May, whose ideas we shall consider later in this unit). Maslow's definition of self-actualisation is that it is a process whereby each person strives to become what they are actually intended to be. People with specific talents like art or music, for example, must develop those abilities in order to be psychologically healthy and at peace with themselves. The need to self-actualise may, of course, take various forms. These include excellence in sport, success in parenting or caring for others, or indeed achievement in any other personal area that has meaning and importance for the individual. One difficulty clients often express in counselling is that they are unable (for various reasons) to develop the skills and natural talents they feel they possess. This inability to fulfil potential can cause a great deal of suffering. Some aspects of this problem have been discussed earlier in this unit in the section dealing with Rogers' concept of self-actualisation.

## Self-actualising people

Maslow studied a group of healthy people, in order to identify their characteristics and to show how they differed from other, less fulfilled, individuals. Maslow described his work as ‘a study of psychological health’ (Maslow, 1970: 125) and selected his subjects from his personal acquaintances and friends. However, he also included a selection of public and historical figures that he studied through biography. Among these were the philosopher Spinoza, Aldous Huxley, Eleanor Roosevelt, Abraham Lincoln and Thomas Jefferson. Maslow’s study points to several significant characteristics his selected group of people seemed to share. These include the following:

- the ability to perceive reality clearly; this includes the ability to judge people and situations accurately
- acceptance of self and of others; this includes acceptance of one’s own human nature, without too much concern about personal shortcomings
- spontaneity in thinking and behaviour, as well as a sense of humour
- the capacity to be problem-centred rather than ego-centred; this means the ability to look outside oneself to the problems of the wider world
- a quality of detachment and an ability to be self-contained when alone
- the ability to resist cultural pressure without being deliberately unconventional
- the capacity to appreciate the good things of life, including everyday experience
- the capacity for heightened or transcendent experience
- interest in social issues and the welfare of other people
- the ability to form deep and satisfying relationships, although these may not be as numerous as those of other people
- originality and creativity and a willingness to experiment with new ideas
- the ability to tolerate uncertainty.

## The significance of Maslow’s work in relation to counselling

Maslow is at pains to point out that the self-actualising people he describes are, in fact, also imperfect in many ways. Many of these people are, he says, sometimes ‘boring, irritating, petulant, selfish, angry or depressed’ (Maslow, 1970: 147). These qualifications are helpful, since they indicate that Maslow’s self-actualising people are, after all, human. Without these qualifications it would be impossible to look at the qualities listed without feeling slightly intimidated by them. However, what Maslow proposes is that there are people who are capable of developing their potential to a very high level, while at the same time remaining essentially human. This, of course, highlights the point that a great many people never achieve this kind of development, and there are others whose innate potential is inhibited for a variety of reasons.

There are many reasons for this kind of inhibition; clients who come into counselling frequently exhibit some, if not all, of them. If we look at the

list again, it becomes clear that the qualities Maslow describes are strikingly absent when people are distressed or emotionally upset, as clients often are. Distressed people find it very difficult to tolerate uncertainty, for example, and they frequently lack spontaneity, creativity and a sense of humour. Perceptions of reality may be very distorted, while acceptance of self and others may be lacking too. Autonomy and self-reliance are easily impaired when problems seem insurmountable, and relationships with other people, if not actually the cause of difficulties, may well suffer as a result of them. Appreciation of life experience is often diminished, and there may be no interest whatever in wider social issues. Transcendent or heightened experiences, which are in any case associated with psychological wellbeing, may be non-existent during a time of crisis or emotional upheaval. However, implicit in the work of both Maslow and Rogers is the belief that people can be helped to overcome their problems, so that some measure of self-actualisation can then be achieved.

One way of helping people to realise their potential is through a truly therapeutic relationship, although this is by no means the only route to self-actualisation. In the next section, we shall look at some of the experiences and relationships Maslow believed could help people to achieve maximum development and fulfillment.

## Psychotherapy and other helping relationships

Maslow points out that ‘psychotherapy has always existed’ in one form or another (Maslow, 1970: 94); these forms of helping include shamanic healing, religion, the physician and the wise man or woman within communities. Common to all is the ability to help people heal themselves, and Maslow outlines what he believes to be the therapeutic characteristics of such relationships. He also highlights the point that many people are helped by untrained workers, who are, nevertheless, often effective in the work they do. These untrained therapists may include nurses, teachers, social workers, psychology graduates, and so on. This is not to suggest that counselling and therapy training is superfluous; on the contrary, it should encourage us to look more closely at those skills and natural abilities which effective helpers do possess. We have already considered some of these qualities in Unit 1, but it is worth reflecting on Maslow’s views in this context. In Maslow’s opinion, clients appear to make more progress when the following factors are present in the helping relationship:

- the helper shows real interest in the client, and a willingness to listen
- there is obvious concern for the client
- the helper’s efforts are clear to the client, which assures the client that he is worthwhile as a person
- the client feels safe and protected, and feelings of vulnerability and anxiety are diminished
- there is an absence of judgmentalism on the helper’s part
- the helper is accepting
- the helper is frank and encouraging

- the helper is kind
- the client perceives that the helper is on his or her side
- the client feels the helper's respect.

(Maslow 1970: 96–97)

## EXERCISE

### Maslow's helping factors

Working individually, look at Maslow's list of helping factors. In the light of what you have learned so far about counselling, are there any other helping skills or conditions that you would add to this? Discuss with other members of your group.

## The helper's attitude

Maslow makes the further point that it is not what is said or done by the helper that seems to make the difference. Rather, it is the presence of certain helper attitudes, unconsciously transmitted, which appear to encourage clients in the process of therapy. There is a close similarity between attitudes discussed by Maslow and those proposed by Carl Rogers in the person-centred approach. If we analyse Maslow's attitudes, we can see that he refers to Rogerian-type conditions, which are implicit in terms such as interest, frankness, accepting, respect, concern and absence of judgmentalism. Furthermore, the idea that the helper's partiality should be perceived by the client is one that clearly echoes the Rogerian concepts of unconditional positive regard and empathy.

The only skill mentioned by Maslow is that of listening. This also ties in with Rogers' (1951) view that therapeutic progress results from the relationship between client and counsellor and may have little to do with any verbal exchanges between them. There are clear implications here for counselling and counsellor training, since it illustrates the importance of self-development and self-awareness as prerequisites for admission to, and progress through, any training programme. Counselling skills can certainly be learned, but personal characteristics are much more difficult to acquire and sustain.

## Therapeutic life experience

It is worth pointing out once again that therapy and counselling are not the only helping activities that facilitate change when people are in crisis or emotional distress. Maslow reminds us that helpers from diverse backgrounds are also effective in these situations, some of which have been mentioned in this section. As well as the helping relationships discussed, however, Maslow also points to the fact that certain life experiences are in themselves therapeutic. Among these are 'good human relationships', education, job satisfaction, creative activities, family security and 'loving and being loved' (Maslow, 1970: 97–8). However, Maslow concedes that certain clients, especially those who suffer from long-term and intractable problems, need the kind of help which can only

be given by trained therapists or counsellors. Furthermore, he is concerned to point out that it should be possible to extend such training to those untrained professionals who already work effectively with clients. This is, in fact, what is currently happening in many areas like social work, nursing, occupational therapy, teaching and church ministry.

## CASE STUDY

### Shirley

In the space of six months both my elderly parents died. At the time I was also changing jobs, and my partner, who was abroad, had his work contract extended. This meant he wouldn't get home for another three months, so along with the stress of my new job and the double bereavement, I felt, mistakenly as it turned out, that I would have to cope with all this on my own. However, I am really fortunate to have good friends, two of whom are particularly close, and they supported me and listened to me when I was at my lowest ebb. This helped me enormously, and when my partner returned he was supportive as well. I don't think I could have survived all those stresses without the help of my friends, my partner and members of my family. Later on though, I went for bereavement counselling because I was troubled by some aspects of my relationship with my mother. I knew I couldn't confide in family or friends about these worries, as they were too private and personal.

**Comment:** This case study, recounted by Shirley, illustrates a point made by Maslow. His research led him to conclude that there are other forms of helping aside from psychotherapy. Maslow suggests that the experience of friendship and secure relationships are in themselves therapeutic. However, he did concede that there may be a conflict of interests in some close relationships, and this is a point that we also highlighted in Unit 1. Shirley was helped and supported by her family and friends, but she reached a point later on when she needed to talk to someone who was not emotionally involved with her or her family.

## The existential approach

The existential approach is one which, more than any other, stresses the individual's capacity for freedom and choice. Earlier in this unit we noted that psychology had, until the middle of the twentieth century, been dominated by two major ideological traditions. The first tradition was that of scientific behaviourism, while the second was Freudian psychoanalysis. Gradually, however, a new tradition began to emerge, whose adherents, including Maslow and Rogers, were convinced of the limitations of behaviourism and psychoanalysis. Behaviourism, with its view that freedom is restricted by social and cultural conditioning was, in their opinion, a limiting one. By the same token, the psychodynamic explanation that unconscious forces also restrict the ability to make free and informed choices seemed limiting too. Behaviourism and psychoanalysis did not, as far as Rogers and Maslow were concerned, acknowledge important human qualities like creativity, self-actualisation, self-awareness, love, choice and freedom. By 1950 they had established a new

force in psychology, which they called humanistic psychology; this later became known as the third force. Many of the ideas expressed by Rogers and his colleagues are similar to those enshrined in the existential approach to therapy. These include the qualities already mentioned, as well as an emphasis on the need to value the unique and subjective world of the individual.

## Further background information

Existential psychotherapy is influenced by the philosophy of existentialism. This philosophical tradition is, in turn, associated with the work of Kierkegaard, Nietzsche, Heidegger and Sartre. These philosophers were concerned with the meaning of human existence and with the concepts of free will, subjectivity and the nature of individual experience. It can be seen, therefore, that humanism and existentialism are closely allied.

In the context of psychotherapy, the existential tradition was established first in Europe, and later emerged as a theoretical approach among certain psychologists in America. In both countries, however, existentialism and psychotherapy were seen to have much in common. Rollo May (1986) makes the point that both these concepts are concerned with people in crisis. Important figures in the European therapy movement include Ludwig Binswanger and Medard Boss, while those within the American tradition include Rollo May, Otto Rank, Karen Horney, Erich Fromm and Irvin Yalom. Within the European therapy framework, the emphasis has always been on the need to face anxiety, uncertainty and the prospect of death. In contrast to this, the humanistic–existential approach in America tended to be more concerned with the development of human potential, self-awareness, a holistic view of the person, the importance of meaningful relationships and the possibility of transcendent experience. Irvin Yalom points out that many of the humanistic and anti-intellectual trends in America were effective in causing a split between humanistic psychology and members of the academic community who were interested in existential issues (Yalom, 1980). Although the humanistic and existential approaches in therapy are now identified as separate, they still have much in common, and humanistic psychologists like Rogers and Maslow retain their association with existential concerns.

The British existential psychiatrist R.D. Laing was another significant contributor to this field, although his focus was somewhat different in the sense that his special interest was schizophrenia. Laing's views were controversial and include, among other things, the belief that people who suffer from severe mental illness may have a clearer grasp of reality than those who do not (Laing and Esterson, 1990). Orthodox psychiatry takes the contrasting view that schizophrenia sufferers are at odds with reality.

## The existential view of the person

In contrast to Freudian theory, which is based on the premise that human behaviour is determined by unconscious forces and past events, the existential approach assumes that people are free and responsible for

their own choices and behaviour. According to the theory, human beings cannot, therefore, escape the necessity of dealing with, and making sense of, existence. The unconscious is certainly acknowledged in existential psychotherapy, but it is not viewed as a repository of culturally unacceptable impulses and desires. On the contrary, it is seen as an often neglected area of human potential which, according to Rollo May, is sometimes difficult for people to actualise (May, 1986). From an existential perspective, fear and anxiety result from an individual's awareness, albeit at an unconscious level that such potential exists and is being neglected. Anxiety or angst is an important concept in existentialism; it refers to feelings of dread that are associated with extreme threat. Perhaps the greatest threat of all is contained in the knowledge that we are indeed free, and if this is true then it follows that we are entirely responsible for how we act and what we do. The first principle of existentialism, in the words of Jean-Paul Sartre, is that 'man is nothing else but that which he makes of himself' (Sartre, 1987: 221). This may seem like a bleak proposition, but it is a fundamental idea in existentialism.

## Application to clients

A central goal of the existential approach to therapy is to help clients become more personally authentic. Authenticity is a prominent theme in the approach; it refers to the individual's ability to define who they are and what they feel. The person who is not authentic accepts, without question, that it is others, including family, culture and religion that are responsible for this important definition. Alienation is seen as a direct result of allowing oneself to become separated or detached from personal experience.

The four dimensions of human experience are the physical, the social, the psychological and the spiritual (Avery, 1996). Physical experiences include our relationship with all our basic needs and with the world around us. Our social experience encompasses our relationships with other people, while our psychological experience is concerned with the way we feel about ourselves and our personal identity. Finally, experience of spirituality describes the individual's relationship with the transcendent, the mysterious or the unknown.

It can be seen from these descriptions that clients do indeed have frequent problems in relation to them. Many clients recount experiences of alienation in relation to themselves and others, while some may feel despair and loss of purpose in life. Isolation and meaninglessness are further problems described by some clients, and these are among the themes highlighted in the existential approach to therapy. Certain significant life stages may also precipitate crises which prompt clients to seek help through psychotherapy and counselling. These include adolescence, mid-life and old age. Other experiences, including bereavement, redundancy or divorce may also act as catalysts for change or a search for meaning. The following case study illustrates this last point.

## CASE STUDY

### Searching for meaning

Mrs Jackson, who was in her early 50s, took early retirement to care for her elderly mother, who was dying. Her relationship with her mother had not been good in childhood, and she hoped to redress the balance by forming a more positive bond before her mother died. Mrs Jackson had spent her life caring for other people. Although she was an intelligent woman she had not gained any satisfactory educational qualifications. She lived with her husband, who had separate interests, while their three children, who were now adults, had left home. Mrs Jackson found the task of nursing her mother much more difficult than she had expected, and the relationship between them did not improve. After her mother's death, Mrs Jackson moved house with her husband, and six months later their new home was burgled. She described her experiences to the counsellor.

**CLIENT:** About two days after the break-in I started to cry and couldn't stop. It was just as if I could take no more . . . first my mother . . . then the move, and now this.

**COUNSELLOR:** It all seemed like too much . . . and in such a short space of time.

**CLIENT:** Yes that's right. And then . . . and then to make it all the more frightening, I found that I didn't believe in anything any more.

**COUNSELLOR:** You lost your faith.

**CLIENT:** I always relied on my faith in God's will. But how can God have willed this? [starts to cry]

**COUNSELLOR:** That is a frightening thought for you . . . To have lost so much, and now to feel that you have lost your faith too.

**CLIENT:** It's terrifying . . . I can't tell you what it's like. It's as if the ground has opened up beneath my feet. I don't know where I am any more.

**COUNSELLOR:** Nothing makes sense to you any more . . .

## Counselling skills

The counsellor worked with this client, in order to help her explore her feelings in relation to her mother's death. Mrs Jackson experienced despair and outrage following the break-in at her new home, and these feelings were also discussed in counselling. After several sessions it became clear that other disturbing issues were causing concern for the client; she was preoccupied

with ideas of her own mortality and with her inability to accept her mother's uncaring attitude towards her when she was a child. She also felt guilty that she had not helped her mother more and blamed her husband for his inability to support her emotionally after her mother's death. The counsellor was concerned to understand the client's subjective experience or internal frame of reference, and, in this respect, the existential approach is similar to Rogers' person-centred view of the helper's role in therapy.

In order to achieve these goals, the counsellor used the skills of active listening, clarification of content and meaning, asking relevant and open questions, and encouraging the client to look more closely at all her beliefs, both past and present, so that she could identify her own inner feelings in relation to these. Throughout her whole life, Mrs Jackson had behaved in a way she thought would please her mother. In fact, this had never worked; and now that her mother was dead, Mrs Jackson realised that she was free to be herself. This realisation of freedom was, in itself, frightening, and this fear presented her with the greatest challenge for the future. A fundamental task for the counsellor was to encourage the client to listen to herself, an exercise that many clients find difficult to undertake. There are no specific techniques in existential therapy, but counsellors who are interested in it need to be skilled in a wide variety of techniques that may be used in other approaches. Existential psychotherapy is often referred to as an intellectual approach, so knowledge of philosophy, psychology and literature are prerequisites for anyone wishing to undertake training in it. The person of the therapist is important as well; and in this approach, more than in any other, self-knowledge is essential.

## EXERCISE

### Ultimate concerns

In existential therapy certain important human concerns are highlighted. Yalom (1980: 8–10) lists four 'ultimate concerns', which, according to him, underlie all existential conflict. These four major concerns are as follows:

- 1 Death
- 2 Freedom
- 3 Isolation
- 4 Meaninglessness.

(Yalom, 1980)

Working in groups of three to four, discuss these concerns, focusing on the ways in which each of them may cause tension and conflict at different stages of life. How may a helper's inability to confront these issues at a personal level affect the therapeutic relationship?

**EXERCISE****Individual freedom**

We tend to think of freedom as a wholly positive concept. However, in the existential sense, freedom has a different meaning and refers to the absence of external structure or security. Working individually, consider the ways in which freedom of choice can cause problems for clients in counselling. What are the factors which inhibit the individual's ability to choose? Afterwards, discuss your views with members of the class group.

**Relationship between counsellor and client**

The therapeutic relationship is the most important factor in the existential approach. It is much more significant than skills or techniques; although this probably applies to any theoretical model, it is certainly emphasised by practitioners of existential therapy. Irvin Yalom, for example, in referring to the relationship between client and counsellor, observes that a positive encounter is 'positively related to therapy outcome' (Yalom, 1980: 401). From both the client's and counsellor's point of view, therefore, the relationship should be real and genuine, which means that the counsellor should concentrate on the quality of the encounter, rather than on the application of techniques designed to help solve specific problems. In order to establish this kind of rapport with the client, the counsellor must first be interested in him or her, and in the story he or she wishes to communicate. This means being receptive and sensitive to all aspects of the client's communication, both verbal and non-verbal.

Rigid theoretical views tend to work against this kind of receptiveness and interest, since they frequently inhibit real person-to-person contact. The experience of true human contact and understanding is what benefits clients most; this experience often convinces them that they are indeed valuable and capable of sustaining not just this relationship, but others as well.

The concept of transference is addressed within the existential approach, but any preoccupation with it, or specific focus on it, is viewed as an impediment to an authentic person-to-person encounter. According to Yalom, 'a singular focus on transference impedes therapy' and shifts attention away from the here-and-now relationship between client and therapist. It also encourages a preoccupation with the client's relationships from the past and minimises the importance of working fully in the present (Yalom, 1980: 413).

**Clients who benefit from this approach**

The existential approach to therapy is appropriate for clients who are concerned about meaning, or loss of meaning, in their own lives. Attitudes to personal freedom and to isolation and loneliness are also addressed from this theoretical perspective. There are a great many clients who do, in fact, suffer

from feelings of isolation and alienation, some of whom would probably benefit from this approach. The experience of isolation and separateness arouses immense anxiety, and such experience may indeed be what Eric Fromm calls the ‘source of all anxiety’ (Fromm, 1995: 7). If clients are to benefit from the approach, however, they need to be committed to it. The aim of existential therapy is not to change people, but to help them accept themselves and to face, with courage, the major issues which concern them and brought them for help in the first place. Clients who are interested in personal growth and greater self-awareness should also benefit from this perspective. Some of the basic concepts of existential therapy can be integrated with other models and, in this way, problems relating to developmental crises, for example, may be addressed. These include issues which arise at certain times, or at certain stages of life. Adolescence, mid-life, retirement, redundancy, illness, disability and divorce are examples. Existential therapy is also sometimes applicable in brief therapy and in certain crisis situations, once the initial trauma phase is over. It can be used in either individual or groupwork settings and is appropriate for use in family therapy too.

## Some limitations

Perhaps the most important point to make about existential therapy is that counsellors who use it should be interested in its concepts and the philosophical tradition from which it stems. Clients who are also interested in existential therapy may seek out practitioners of it. On the other hand, there are clients who are not versed in the theory of existentialism but who benefit anyway. This is because effective counselling and psychotherapy should be tailored to the needs of individual clients, regardless of the theories behind it. It is quite possible for counsellors who are informed by existentialism and its concerns to work with clients in an accessible way. The language of existentialism is fairly esoteric and some clients may not understand it. Existential concepts tend to appeal to people with an intellectual orientation, but this does not mean that it cannot also encompass emotional issues. The types of insights it offers may not be useful to people who are in poverty, dispossessed, homeless or suffering from mental illness. Certain environmental factors may limit personal options, so it may be difficult for people in any of these groups to feel they have the type of choices the existential focus suggests.

## Transpersonal psychology

Another significant approach to helping clients has emerged since the early 1970s. This approach, called transpersonal psychology or transpersonal therapy, is also sometimes referred to as a fourth branch of psychology, since it follows on from the Freudian, behavioural and humanistic approaches. In addition, transpersonal counselling and psychotherapy incorporates

many elements of humanistic, Jungian and existential psychology. Another important dimension of the transpersonal approach in counselling and psychotherapy is a focus on spirituality (Rowan, 2005). There is an implicit understanding that therapy must facilitate each person's total experience, including different states of consciousness, awareness of a higher or spiritual self, and a connectedness to something transcendent or 'transpersonal'. The word transpersonal means 'beyond the personal' and denotes an acceptance that each person is complex, with many layers of experience, many of which are outside the merely personal or material. There is a close connection here with Jung's concept of the collective unconscious, which points to a layer of human experience shared by everyone.

Consideration of the spiritual dimension is not an entirely new idea in counselling and psychotherapy. All major approaches accept that clients have different levels of experience that are individual to them and should be respected and acknowledged. However, the transpersonal approach is different in that it highlights spiritual experience and openly discusses it. Transpersonal psychology could, therefore, be described as a uniquely metaphysical approach, and one that gives permission to incorporate an aspect of human experience formerly neglected. It should be added that transpersonal psychology is not a specifically religious approach, though it does recognise the transcendent experiences which people of different religions sometimes have.

A central focus of transpersonal counselling and psychotherapy is integration of every aspect of each client's experience. There is an emphasis, too, on self-actualisation and personal empowerment. It can be seen, therefore, that transpersonal therapy has much in common with the person-centred and humanistic approaches of Maslow and Rogers, both of which stress these aspects of client development.

## Clients who benefit from this approach

Counsellors and psychotherapists who are informed by the transpersonal approach use the range of skills described in Unit 2. They also use a variety of other techniques with individual clients. These skills and techniques include guided imagery, meditation, creative therapies and working with dreams, to name just a few. Accredited practitioners work with clients in both individual and group settings. Client problems include eating disorders, bereavement, self-harm, relationship difficulties, life-threatening illness and sexual problems.

## Some limitations

In common with every other approach to helping clients, transpersonal psychology is not without its critics. The emphasis on a spiritual dimension of human experience is problematic for some people, though it is difficult to

see how such a reservation would interfere with any therapist's willingness to work with particular clients. However, the reservation about working with a spiritual perspective is not applicable, obviously, to those counsellors and psychotherapists who specifically choose the transpersonal approach as their preferred way of working with clients. Those students who are interested in learning more about transpersonal psychology and therapy should refer to the list of books for further reading given at the end of this unit, along with relevant websites and other resources.

## EXERCISE

### Personal experience and spiritual awareness

Working in pairs, discuss your understanding of the term spiritual awareness. Does it have meaning for you and, if so, how is it shown in your personal experience?

## SUMMARY

In this unit we looked at the concepts of phenomenology and humanism in relation to counselling. The person-centred and existential approaches were discussed in some detail, and the work and influence of Maslow was highlighted. In addition, we included a section on transpersonal psychology and therapy, with an emphasis on its transcendent or spiritual focus. Comparisons were made between these models and the psychodynamic approaches dealt with in the previous units. The nature and importance of the therapeutic relationship was highlighted within each approach, and the concept of transference and its various interpretations was also considered. The need for adequate training in all aspects of theory and practice was emphasised, and some of the difficulties in the existential perspective were outlined. We looked at the benefits and limitations of each theoretical model, and considered the counselling situation in which each might work effectively for clients.

In this unit, we also discussed in some detail the effectiveness of person-centred counselling with elderly clients and older people who find themselves in the role of carer for ill or disabled relatives. In addition, a selection of research projects, indicating the importance of person-centred communication in these contexts, was included. The central role of training for health and social care staff was highlighted, along with the difficulties in achieving this without the involvement of staff at all levels. Commitment to the concept of person-centred care was seen as a prerequisite for senior as well as junior staff. The problem of organisational or bureaucratic structures that could impede adequate training was indicated as a possibility in any large organisation.

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## Further reading

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## Resources

- [www.transpersonalcentre.co.uk](http://www.transpersonalcentre.co.uk)  
The Centre for Transpersonal Psychology. A member of the Humanistic and Integrative Psychology section of the United Kingdom Council for Psychotherapy (UKCP).
- [www.bapca.org.uk](http://www.bapca.org.uk)  
The British Association for the Person-centred Approach.
- [www.existential-therapy.com](http://www.existential-therapy.com)  
Links to various sites offering theory and topics for discussion.
- [www.maslow.com](http://www.maslow.com)  
The official Maslow publications site.
- [www.carlrogers.net](http://www.carlrogers.net)  
General information about Carl Rogers.
- [www.carlrogers.info](http://www.carlrogers.info)  
Resources for students, researchers and practitioners.
- [www.psychotherapydvds.com/rogers](http://www.psychotherapydvds.com/rogers)  
Carl Rogers in interview.