NOT THE BODYWORK, THE EXERCISES, OR THE DIET BUT THE BITS IN BETWEEN ...

OR

Communication Aspects of Polarity Therapy

Stephanie Aucote RPP

Preface

What follows is a compilation of essays on the communication and facilitation aspects of Polarity Therapy, which I produced as part of my formal training in Polarity Therapy with Masterworks International. The work on the counselling approaches of Carl Rogers and Fritz Perls was the most arduous task I was set - to produce the critical analysis of something I had no Knowledge or experience of. I managed to get books and articles from my sister who is a psychotherapist. I felt the best way for me to cover this uncharted ground was to set out theory and practice then draw conclusions. This protracted and at times frustrating process proved to be a most useful learning experience for which in the end I was grateful.

Observations during the research

At first I was annoyed at the work I had undertaken. I reckoned if l had wanted to be learn about it in detail I would have chosen to be a counsellor not a Polarity Therapist. For me words are not direct enough to be the only means in the full process of healing to a state of well-being. As I read the stuff and began to understand it through the jargon, which was alien to me, I realised it was useful to have covered this. I had three clients at that time who had a lot of counselling before they came to me and a close family member was also having some. I felt I could now share more of their world.

Even more interesting to me, as an energy worker, I **realised the energy of the styles of counselling resonated in me during the research**:- I started with Gestalt; it certainly got me riled up and prompted this angry note to myself- "l am aware I am not enjoying this essay. I resent spending time researching and writing about a process I am not interested in — if I was I'd have studied counselling or psychology not Polarity Therapy!" The language of the Person Centred Therapy books and articles is watery, flowing, verbose — it drew me in and I wrote and quoted reams! I set arbitrary, wishy washy, goals for essay finish dates. I stopped enjoying the process, the journey.

The bread in this sandwich is made from my communication recipe, the tilling consists of the counselling styles I was obliged to get my teeth into — it's all a matter of personal taste!

Stephanie Aucote

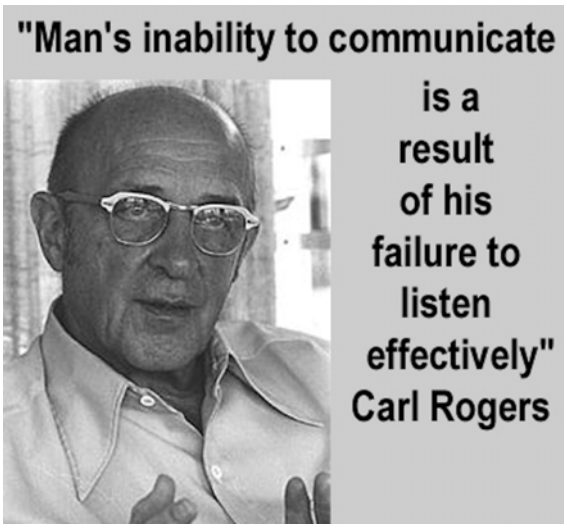
A CRITIQUE OF THE COUNSELLING APPROACHES

OF CARL ROGERS AND FRITZ PERLS

GESTALT

COMMUNICATION IN POLARITY THERAPY

CARL ROGERS - PERSON-CENTRED COUNSELLING



('Quotes' are from Brian Thorne, 'quotes ' are from Atkinson - see end refs.)

HISTORICAL DEVELOPMENT

Dr. Carl Rogers (1902 - 87), founder of what is known now as person -centred counselling, was influenced by many significant figures often holding widely differing viewpoints. He claimed above all he was a student of his own experience and that of his clients and colleagues. (Students of yoga and Polarity Therapy will relate to that, i.e. real knowledge coming from personal experience). He is described as being 'in the tradition of no nonsense, of vigorous self-reliance, of exposing oneself thoughtfully to experience, practical innovation, and of careful concern for others." (Thorne). This comment could equally be made of Dr. Stone.

His first appointment in 1928 was as a member of the Child Study Dept. of the Society for A Prevention of Cruelty to Children in Rochester, New York where the three fields of psychology, psychiatry and social work were combining forces in diagnosing and treating problems. Having an essentially pragmatic temperament, Rogers became progressively disillusioned with the activities of diagnosis and interpretation during his time at Rochester.

Rogers felt the breakthrough came when the mother of a child who was being treated for behavioural problems requested counselling for herself which resulted in outpourings of her own despair, marital difficulties etc. Prior to that Rogers had been convinced the root of the problem lay in the mother's early rejection of the boy but his gentle strategies were not bringing her to this insight. Rogers wrote this incident, amongst others, helped me experience the fact – only fully realised later- that it is **the client who knows what hurts, what direction to go, what problems are crucial, what experiences have been deeply buried**". The essential step **from diagnosis and interpretation to listening** had been taken and from then on Rogers was launched on his own path of client led sessions rather than therapist directed.

By 1940 Rogers was a professor of psychology at Ohio State University. His first book 'Counselling and Psychotherapy' appeared two years later and in 1951 he published 'Client Centred Therapy'. ln Britain, Rogers' main influence was through the Marriage Guidance Council (now 'Relate') and the first training courses for school counsellors.

Rogers felt he was giving clear expression to an idea whose time had come. The idea was " that the individual has within himself vast resources for self-understanding, for altering his self concept, his attitudes and his self—directed behaviour- and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided".

The theoretical views of Carl Rogers and Abraham Maslow lie at the centre of the **Humanistic movement**. Humanistic psychologists reject the psychoanalytic approach believing that "*a psychology based on crippled personalities could only produce a crippled psychology.*" They also reject behaviourism," *psychology devoid of consciousness derived primarily from the study of lower organisms*." People are not simply motivated by basic drives like sex or aggression or physiological need like hunger and thirst. They have a need to develop their potentials and capabilities. Growth and self—actualisation should be the criteria of psychological health, not merely ego control or adjustment to the environment. The central question each person must face is 'Who am I?'

Rogers came to believe that the basic force motivating the human organism is the **actualising tendency** — a tendency towards fulfilment or actualisation of all the capacities of the organism. A growing organism seeks to fulfil its potential within the limits of its heredity. A person may not always readily perceive which actions lead to growth and which actions are regressive. But once the course is clear, the individual chooses to grow rather than regress. Rogers did not deny that there are other needs, some of them biological, but he saw them as subservient to the organism's motivation to enhance itself.

Rogers' belief in the primacy of actualisation forms the basis of his non-directive or client—centred therapy. This method of psychotherapy asserts that every individual has the motivation and ability to change and that the individual is the person best qualified to decide on the direction such change should take. The **therapist's role** is to act as a sounding board while the individual explores and analyses his or her problems. This approach differs from psychoanalytic therapy, during which the therapist analyses the patient's history to determine the problem and devise a course of remedial action. The person-centred therapist must become a partner with the individual in the quest for existential meaning. **3 main qualities a PC Therapist needs towards his client are - unconditional positive regard, congruence and accurate empathy.** Emphasis was placed on a relationship between counsellor and client, based on acceptance and clarification. Also at this time recorded interviews were used for research and training with the **focus on non-directive techniques.**

Those coming for help were no longer referred to as patients but **clients**, the inference being that they were self-responsible human beings, not objects for treatment. The term '**client-centred therapy'** was adopted which put emphasis on the internal world of the client and focused attention on the attitudes of the therapists to their clients rather on particular techniques. When Rogers started working in the USA in l920's, psychologists were not allowed to practice psychotherapy so he called his activity '**counselling**'. British practitioners have tended to use the word 'counsellor' and not psychotherapist perhaps for different reasons. The word psychotherapist is somehow conducive to an aura of mystification and expertise which runs counter to the egalitarian relationship PCC espouses. (*It is interesting to note that Polarity Therapists cannot use the term 'counselling' for that aspect of the practice).*

The term '**person-centred'** won Rogers' approval before he died because it can be applied to the many fields outside therapy where such ideas are accepted and valued.

(e.g. 'Person-centred planning' — a process, initially to help people with learning disabilities identify and choose how they want to live in the changing community but now used to assist people with all disabilities to make life plans).

In the therapy itself the term underlines the person-to-person nature of the interaction where not only the phenomenological world of the client but also the therapists state of being are of crucial significance.

Although Rogers set out clear principles and guidelines he encouraged growth in the method, as did Dr. Stone in Polarity Therapy. Thorne cites his own thinking and practice as evidence that Person-centred Counselling theory and practice is 'in no sense a closed system and is constantly being refined and developed by the practitioners.'

THEORY/CONCEPTS IN PCC

Trust- in the actualising tendency of humans

Person-centred therapists start from the theory that both they and their clients are trustworthy. This trust resides in the belief that every organism has an '**underlying and instinctive movement towards the constructive accomplishment of its inherent potential**.' (*This can be likened to the polarity principle that life moves in involutionary/evolutionary cycles*). This tendency is exemplified by clients whose lives have been warped by circumstances and experience but who continue against all odds to strive towards growth, towards becoming. This directional, or actualising, tendency in human beings can be trusted and the therapist's task is to help create the best possible conditions for its fulfilment- *as in polarity therapy.*

Self-concept, organismic self and ideal self- the route to psychological disturbance and the role of significant others

The self-concept is of crucial importance in PCT and needs to be distinguished from the self. Self is the real underlying **organismic self**, the essentially trustworthy human organism. This is contrasted with the self-concept which is a person's conceptual construction of himself, however poorly articulated, and which does not always correspond with the direct experience of the organism itself. This consists of all the ideas, perceptions and values that characterise "me" or "I"; it includes the awareness of "what I am" and "what I can do". This perceived self in turn influences both the person's perception of the world and his or her behaviour. The self-concept does not necessarily reflect reality: a person may be highly successful and respected but still view himself as a failure.

According to Rogers, the individual evaluates every experience in relation to this self-concept. People want to behave in ways that are consistent with their self-image: experiences and feelings that are not consistent or threatening may be denied admittance to consciousness. This is essentially Freud's concept of repression, though unlike Freud, Rogers felt that such repression is neither necessary nor permanent. The more areas of experience that a person denies because they are inconsistent with his self-concept, the wider the gulf between the perception and reality and the greater the potential for maladjustment. An individual whose self-concept is incongruent with personal feelings and experience must defend himself against the truth because the truth will result in anxiety. lf the incongruence becomes too great, the defences may break down, resulting in severe anxiety or other forms of emotional disturbance. The well-adjusted person, in contrast, has a self-concept that is consistent with thought, experience and behaviour; the self is not rigid but flexible and can change as it assimilates new experiences and ideas. The other self in Rogers' theory is the IDEAL SELF. We have a conception of the kind of person we would like to be. The closer the ideal self is to the real self, the more fulfilled and happy the individual becomes. A large discrepancy between the ideal and the experiencing self results in an unhappy, dissatisfied person.

Thus 2 kinds of incongruence can occur:-

1. between the self-concept and the experiences of reality

2. between the self-concept and the ideal self

Rogers believed people are likely to become fully functioning if they are brought up with **unconditional positive regard**. This means that they feel valued by parents and others even when their feelings, attitudes and behaviours are less than ideal.

e. g. Feelings of hostility towards younger siblings are natural, but parents disapprove of hitting a baby brother or sister and usually punish such actions. Children must somehow integrate this experience into their self concept. They may decide that they are wicked and so feel ashamed They may decide that their parents do not like them and so may feel rejected Or they may deny their feelings and decide they do not want to hit the baby. Each of these attitudes contains a distortion of the truth. The third alternative is the easiest for children to accept but in so doing; they deny their real feelings, which then become unconscious.

e.g. Full-throated howling gives the child relief but is punished or condemned by his mother. At this point the need to win mother's approval is in immediate conflict with the promptings of the organismic self which wishes to howl. (*The mother's requirement that the baby cease to howl constitutes a **'condition of worth'** in person-centred terminology*).

The more people are forced to deny their own feelings and to accept the values of others, the more uncomfortable they will feel about themselves. Rogers suggested the best approach is to for the parents to recognise the child's feelings as valid while explaining the reasons why hitting is not acceptable. In the person centred tradition **disturbance is conceptualised in terms of the degree of success or failure experienced by the individual in resolving such conflicts**. The badly disturbed person on this criterion will have lost almost complete contact with the experiencing of the organismic self, for the basic need for self-regard can in most adverse circumstances lead to behaviour which is totally geared to the desperate search for acceptance and approval. **This can be compared with Ruth Ann Pippenger's interpretation of the 4 elements in communication, in particular 'negative water' where the self is not taken into account; the concern is only for the other.**

Self-concept develops over time and is heavily dependant on the attitudes of those who constitute the individual's **significant others**, (parents, partners etc). Therefore, where a person is surrounded by those who are quick to condemn or punish, (however subtly), the behaviour which emanates from the experiencing of the organismic self will become rapidly confused. The need for positive regard or approval from others is overwhelming and is present from earliest infancy. If therefore behaviour arising from what is actually experienced by the individual fails to win approval an immediate conflict is established. "

The self-concept then becomes the fiercest enemy of the self and must undergo radical transformation if the actualising tendency is to reassert itself- i.e. *rediscover the self*. Nowadays advertisers, so-called image-makers and peer pressure increase the tendency for us to be alienated from our organismic selves.

The PC Therapist is constantly working with clients who have 'all but lost touch with the actualising tendency within themselves and who have been surrounded by others who have no confidence in the innate capacity of human beings to move towards the fulfilment of their potential.' (*Hence the benefit in treating the significant others, the knock on effect)*. **The therapist takes on the role of 'significant other' to the client in order to have an actualising influence.**

Such people become preoccupied with a sense of strain at having to come up to the mark with these 'conditions of worth' or feelings of worthlessness at having failed to do so. They will be victims of countless introjected conditions of worth so that they no longer have any sense of their s inherent value as unique persons.

Introjection is the process whereby the beliefs, judgements, attitudes or values of another person, (most often the parent), are taken into the individual and become part of his armoury for coping with experience, however alien these

values might have been initially. The need for positive regard over-ride the rejection of attitudes and beliefs that may run counter to his own organismic reaction to experience. Once such attitudes and beliefs have become thoroughly absorbed into the personality, they are said to have become **internalised**.

Introjection and internalisation of conditions of worth, imposed by significant others whose approval is desperately desired, often constitute the gloomy road to a deeply negative self-concept as individuals discover they can never come up to the high demands and expectations which such conditions inevitably imply.

Once this negative self—concept has taken root it is likely that the separation from the essential organismic self will become increasingly complete as the person is governed by a secondary and treacherous valuing process which is based on the internalisation of other people's judgements and evaluations. Low self- esteem and a negative self-concept is usually a sign of disturbance at some level.

Behaviour

Once in this trap the person is likely to become increasingly disturbed as the negative concept induces **behaviour** which reinforces the image of inadequacy and worthlessness. Thorne explains it is a fundamental thesis of the person-centred view point that behaviour is not only the result of happens to us from the external world but also a function of how we feel about ourselves on the inside. i.e. We are likely to behave in accordance with our perception of ourselves. (e.g. Anorexics will deprive themselves of food to a skeletal state because they still see themselves as fat.) It is likely too that we shall be highly conscious of a sense of inadequacy although we may conceal this from others.

Awareness of the problem

However **psychological disturbance is not always available to awareness**. It is possible for us to establish a self-concept which, because of the over-riding need to win approval from others, cannot permit highly significant sensory or visceral, (Rogers' term), experience into consciousness. (*This is where body-work comes in to its own to help release such blockages `more quickly than talking round the subject).*

e.g. Someone with the picture of himself as honourable, virtuous, responsible and loving may arrive at a point when he no longer knows that he is angry, or hostile or sexually hungry for to admit such feelings throws his whole picture of himself into question.

Disturbed people therefore are not always aware of their disturbance nor will they necessarily be perceived as disturbed by others who may have a vested interested in maintaining the act of self-deception. (i.e. co-dependency).

The voice of the organismic self in such cases is silenced and a self-concept is developed which bears little relationship to their deepest promptings from which they are essentially cut off. Such attempts to create a self-concept, which denies the nature of the self, cannot in the long run be successful.

It follows, from the person-centred viewpoint, psychological disturbance will be perpetuated if an individual continues to be dependent to a high degree on the judgement of others for a sense of self-worth. *They will be at pains to preserve this approval winning self-concept*.

e.g. The 'virtuous' man would be subject to feelings of threat and confusion if he directly experienced his hostility or sexual hunger although to do so would be a step to recovery of contact with the organismic self. He will likely avoid this threat by resorting to basic defence mechanisms of **perceptual distortion or denial.**

Perceptual distortion takes place whenever an incongruent experience is allowed into awareness but only in a form that is in harmony with the person's self-concept. The 'virtuous' man might permit himself to experience hostility but would distort this to as a justifiable reaction to the wickedness in others.(*Which of us has not been there — Morag this reminds me of my helpful dream of truly experiencing my anger*).

Denial, according to Thorne is less common but more impregnable. ln our example the virtuous man would be totally unaware of his constantly angry attitudes in a committee meeting and might perceive himself as speaking truthfully and sincerely.

Distortion and denial can have formidable psychological consequences and can sometimes protect a person for a lifetime from the confusion and anxiety which could herald the recovery of contact with the alienated self. (**See stages**)

Lack of trust in own iudgement.

Disturbed people can seldom trust their own judgement and for the person centred therapist another sure mark of disturbance is the individual's inability to trust his own thoughts and feelings when making decisions or choosing courses of action. They constantly turn to external authorities or find themselves caught in a paralysis of indecision. *Yes I know that place!*

Summary - disturbance may be conceptualised as a greater or lesser degree of alienation from the organismic self prompted by the fundamental need for self-regard. "The resulting self-concept, usually negative, always false, is linked to a defective capacity to make decisions, which in turn indicates the absence of an internalised locus of evaluation." e.g. ln polarity terms, Head and heart conflict, mind and body, watery loops of behaviour.

How to bring about positive change

Thorne contends that for people who are so deeply trapped there is little hope of positive change unless there is movement in the psychological environment which surrounds them. Most commonly

• the advent of a new person on the scene. (e.g. A teacher's respect for the child which is not dependent on her being 'a good glrl').

• or a marked change in attitude in someone who is closely involved. (proof of the value of treating significant others).

For clients beginning therapy, the most important fact initially is the entry of a new person (the therapist) into their psychological environment. PCC firmly holds that the quality of this new person and the nature of the relationship, which the therapist offers, will ultimately determine whether or not change will follow.

(**I find this is not the whole picture. Being purely psychological, it does not take account of the therapeutic benefit of change in the physical environment- e.g. serious life events like job-loss, accident etc. Neither does this allow for any physical effects i.e. 'biology is biography.)**

Psychologlcally healthy persons are lucky enough to live in contexts which allow them to be in touch at least part of the time with their deepest feeling or experiencing without censure or distortion. These are well placed to achieve a level of psychological freedom to move in direction of becoming '**fully functioning persons**'. (Rogers' term to denote individuals who are using their talents and abilities, realising their potential, and moving towards a more complete knowledge of themselves).

- See Appendix 1 - Characteristics of a fully functioning person.

THE PCC APPROACH

Thorne insists there are no integral strategies or techniques in the PCT approach. It is essentially based on "the experiencing and the communication of attitudes and these attitudes cannot be packaged in techniques".

Misconception

At earlier points in this approach there was an emphasis on the ebb and flow of the therapeutic interview and much was gained from microscopic study of the client-therapist exchanges.

However to Rogers' horror, the tendency to focus on the therapist's responses had the effect of "so debasing the approach that it became known as a technique. Even now there are people who believe that PCT is simply the technique of reflecting the client's feelings, or worse still, that it is primarily a matter of repeating the last words spoken by the client." Not So!"

Therapist attitudes & skills required

The attitudes required of the therapist demand the highest level of self-knowledge and self-acceptance. Thorne believes translating them into communicable form requires a skill which springs from one's own personality and cannot be learned through merely imitating Rogers or anyone else.

Rogers' 'Three core conditions' — facilitative attitudes of the therapist :-

1. **Congruence** (Genuineness, realness, authenticity). This depends on the therapist's capacity for being properly in touch with the complexity of feelings, thoughts and attitudes which will be flowing through him as he seeks to track his client's thoughts and feelings. PC Therapists have to be 'people of real flesh and blood, willing to be known". Rogers required them to be deeply and fully involved in the relationship without pretence and without the protection of professional impersonality.

2. **Total acceptance** Perhaps the most critical in PCC. The conditions of worth which have warped and undermined the self-concept of the client are the outcome of the judgmental and conditional attitudes of those close to the client which have often been reinforced by society or cultural norms. In contrast the therapist seeks to offer the client unconditional acceptance, a positive regard or caring, a non-possessive love. **NB this is total acceptance of the client as he is in the present** not of the person he might become! his yet unfulfilled potential. (*This can be a difficult one!)*

3. **Empathetic understanding** Rogers wrote in 1975, 'of the 3 core conditions, empathy is the most trainable'. Thorne reckons such empathetic understanding requires the therapist to be willing to enter the private perceptual world of the client and to become thoroughly conversant with it. This demands a high degree of sensitivity to the moment-to-moment experiencing of the client so that the therapist is recognised as a reliable companion even when contradictory feelings follow each other in rapid succession.

Thorne argues for a 4th quality in the person-centred therapist- **Tenderness.**

He describes this as an ability to move between the worlds of 'the physical, the emotional, the cognitive and the mystical without strain' and a willingness to 'accept and celebrate the desire to love and be loved if and when it appears in the therapeutic relationship.'

THE PROCESS/PHASES

Ref Thorne - 1988 with Mearns - Most productive outcomes seem to result from therapeutic relationships in PCC which move through 3 distinct phases:-

1. Establishing trust on the part of the client- can be quick or take months

2. Development of intimacy during which the client is enabled to reveal some of the deepest

levels of his experiencing

3. Increasing mutuality between therapist and client. At this stage it is likely the therapist will be increasingly self-disclosing and will be challenged to risk more of himself in the relationship.

Goals

The PCT seeks to establish a relationship with the client in which he can dare to face the anxiety and confusion which inevitably arise once the self—concept is challenged by the movement into awareness of experiences which do not fit its current form. The client can then move beyond the confusion and gradually experience the freedom to choose a way of being which approximates more closely to his deepest feelings and values. **The PCT will therefore focus on communion with the client rather than problems and solutions.**

The **theoretical end-point of PCT** is the fully functioning person who is the embodiment of psychological health and whose primary characteristics are listed in Appendix 1. Thorne, with all his experience, feels it is fairly safe to assert that 'no client has achieved such an end point and no therapist has been in a position to model such perfection'. (*That gives me some comfort in my strivings!*)

Research in the USA and Germany, (see appendix 2), produced a list of **ten common client changes in PCC** and concluded that for many clients the achievement of any one of the listed developments could constitute a goal of therapy and even a valid and satisfactory reason for terminating therapy. (*Again this is a psychologist's list and therefore only covers only mental & emotional changes).*

Best scenario

The process begins with the therapist providing an atmosphere of warm caring and acceptance, gradually experienced by the client as safe. With this realisation the client changes the emphasis of the sessions from dealing with reality problems to experiencing himself. He begins to **experience feelings in the immediate present without inhibition**. Can be angry, childish, hurt, joyful, self-deprecating, self-appreciative and as he allows this to occur he discovers many feelings bubbling through into awareness which he was not previously conscious of. With new feelings there come new thoughts and the admission of all this fresh material into awareness leads to a **breakdown of the previously held self-concept.**

Then follows a period of **disorganisation and confusion** although there remains a feeling that the path is the right one and that reorganisation will ultimately take place. During this period he learns that it pays to recognise an experience rather than denying or distorting it. In this way the client becomes **more open to experience** and realises that it is healthy to accept feelings whether positive or negative for this permits movement to greater completeness. At this stage **client realises he can define himself** and does not need to accept the definition and judgement of others. A

conscious appreciation of the nature of the relationship with the therapist and the value of **a love that is not possessive and makes no demands.** (*Therapist fees/ attitude to money could impede this?)*

Then the client finds he can make relationships **outside therapy** which enable others to be self-experiencing and self-directing and he is aware that the core of his being is not destructive but genuinely desires the well-being of others. Self responsibility continues to increase to point where client feels able to make own choices, though not always pleasant, and trust himself in a world which offers opportunities for creativity and relating.

As the self-concept moves to a more positive view, so too the **client's behaviour reflects the improvement** and enhances further his perception of himself. If therapy is successful, clients will also have learned how to be their own therapist. It seems that when people experience the genuineness of another and a real attentive caring and valuing by that other person, they begin to adopt the same attitude towards himself. (*water energy again, but reinforcing the positive rather than the previous negative).*

i.e. If cared for, the client feels at a deep level worth caring for; if at the receiving end of concentrated listening and empathetic understanding he tends to develop a listening attitude to himself Gradually he is less afraid to get in touch with what is going on inside. Growing attentiveness leads to increased self understanding, the ability to treat himself with respect and take the risk of listening to what he is experiencing.

SUMMARY - It was Rogers' contention that if the therapist can offer a facilitative climate where genuineness, acceptance and empathy are all present then therapeutic movement will almost invariably occur. 'In such a climate, clients will gradually get in touch with their own resources for self-understanding and will prove capable of changing their self-concept and taking over the direction of their life.'

LIMITATIONS OF THE APPROACH

• Because it is client-led with no analytical or directive input from the therapist, PCC is a **lengthy process,** demanding of therapist's time and purse ofthe client or NHS. Person-centred therapists are required to be 'faithful companions, following the lead which their clients provide and staying with them as long as necessary'—*but what about the modern need for a fast fix?*

• PCC is often criticised for its traditional emphasis on the '**here and now'** and what is seen as its **heavy reliance on verbal interaction.**

Thorne contends that 'both these tendencies are likely to be reinforced when the therapist's congruence remains at a relatively superficial level.' That is, if the therapist has not truly entered the client's world, he will only be able to focus on the 'here and now' neither will he be able to give the appropriate non-verbal signals, (e.g. body language, caring physical contact).

As with other 'counselling only' therapies, the reliance on verbal contact only opens the possibility of the client phoning up at odd times for therapy. Whereas those of us who have body work techniques as well need to be in physical contact with the client so it is easier to keep to an appointments system. (*That is not to say we don't give urgent counselling over the phone*)

• The person-centred therapist communicates primarily, if not solely, with the water aspect of energy. **He cannot make use of the full range of elements in communication** because he is bound to be client-led and must remain in the here and now. He cannot take advantage of the air element, the broader perspective, nor use the inspirational or directing

aspects of tire. To do so would be injecting ideas, advice and moving away from the principles of being client led. He cannot input any objective perspective, (earth), because the therapeutic arena has to remain the subjective world of the client.

• Person-centred therapy contends that the self-concept influences both the person's perception of the world and his behaviour, that people want to behave in ways that are consistent with their behaviour therefore, if you change the self-concept, you will change behaviour. Despite this basis, PCT is criticised for its **failure to change behaviour**. Thorne is convinced this limitation is not inherent in the approach. He suspects that clients who are in the grips of behavioural disorders e.g. phobias or obsessive compulsive neuroses are unlikely to be helped by PCT unless they conceptualise their difficulties as being an outcome of their way of being in the world. 'If they view their disorder as a 'disability' to be cured, as often the case, then they are more likely to be rewarded by a visit to the nearest behavioural therapist.'

• Client types

Person-centred therapy has proved effective with clients presenting a wide range of difficulties and concerns. Its usefulness with even psychotics was established when Rogers and his associates anticipated in an investigation into its effectiveness on schizophrenics. However, Rogers himself suggested that psychotherapy of any kind is probably of the greatest help to people who are closest to a reasonable adjustment to life. Thorne admits that in his own experience certain clients are unlikely to be helped much by the approach:-

'. .... usually those somewhat rigid and authoritarian in their attitude', Such people look for certainties, 'for secure structures and often for experts to direct them on how they should be and what they should do'. (*I can see the PCC system would be too loose and watery for these earthy types*).

Also 'intellectual or logical rational people may find it difficult to engage in the kind of relationship encouraged by PCT', where change comes from facing painful and confusing feelings which cannot always be clearly articulated.

Thorne does point out that inarticulacy itself is <u>not</u> a barrier in PCT as he has found that inarticulate people are often brimming over with unexpressed feelings which pour out once a ` relationship of trust has been established. Apparently, people who gain most from PCT are strongly motivated to face painful feelings, are deeply committed to change, are prepared to take emotional risks and want to trust even if they are afraid of intimacy. (*Thank goodness we do not have to expect so much of a PT client! Mostly they just want techniques and advice to help them be pain free. The rest may or may not be required along the way in any one individual case).*

• I feel that one of the strengths of this approach, the **emphasis on empathy,** could also be a weakness. The person-centred therapist needs to be himself or else he is in danger of falling into the trap he is trying to help the client out of! — Entering the client's world so deeply the therapist's own self-concept is distorted.

Thorne relates a case when he made the costly mistake of trying to empathise with a female client- 'it seemed as if her frame of reference was so removed from mine, the more I tried to come along side her the more elusive she became.' He gave up trying to empathise with her and contented himself with listening and simply being present to her. She relaxed more and opened up.

• Thorne believes the limitations of the approach are a reflection of the **personal limitations of the therapist,** which vary individual to individual. *This criticism surely applies to all therapies but perhaps more so to the person-centred therapist because he has no diagnostic labelling system nor a complex or detailed theory of personality to help him gain insight through interpretation*.

• Linked to the previous point, PCT is often criticised for making the **heaviest demands on the therapist**. Clients must perceive them as trustworthy and dependable as people or the therapy cannot take place. They cannot gain their clients' confidence by demonstrating their psychological expertise because to do so would place another obstacle in the way of the clients' movement to trusting their own innate resources. Person—centred therapists can only be as trustworthy for another as they are for themselves. The qualities of the therapist cannot be simulated for very long, (and PCT is a lengthy process!) Therapists' attitudes to themselves are crucial. They must have a deep level of self-acceptance. They have to trust themselves to acknowledge and accept their own feelings without adverse judgement or self-recrimination. Ref. Thorne - 'lf l am in constant fear of being overwhelmed by an upsurging of unacceptable data into my own awareness then I am unlikely to convey to my client that I am genuinely open to full exploration of my own doubts and fears.' The ability of the therapist to be **genuine, accepting and empathetic**, fundamental qualities required in PCT, is not developed overnight. All therapists, whatever discipline or school they follow, need to be continually seeking to broaden their own life experience. No therapist can confidently invite his client to travel further than he has journeyed himself but for the PCT the quality, depth and continuity of his own experiencing becomes the cornerstone of competence he brings to his professional activity. 'Unless I have a sense of my own continuing development, I shall lose faith in the process of becoming and shall be tempted to relate to my clients in a way which might reinforce them in a past self-concept. I myself will become stuck in a past image of myself.' It also follows, that an excessive reliance on particular skills may lead to a professional behavioural pattern which is itself resistant to change becomes it becomes set or stylised.

The key in all successful therapeutic communication is to be able to adapt to the circumstances whilst being a developing and genuine self but it seems that in PCT it is even more crucial. i.e. The therapist has to embody the PCT principles.

• Person-centred therapists are required to **invest themselves freely and fully in the relationship with the client.** They believe they will gain entry to the client's world through an emotional commitment in which they are willing to involve themselves as people and to reveal themselves. Not everyone will be comfortable with this requirement. It could be an exhausting process for the therapist. It also requires discernment on the part of the therapist- 'although ` clients need to experience their therapists' essential humanity and to feel their emotional involvement, they do not need to have all the therapists' feelings and thoughts thrust down their throats.'! They need to have the discrimination to know how and when to communicate what they are experiencing.

• **Who benefits from the counselling sessions- therapist or client?**

Thorne worries that the complete sharing relationship between client and therapist can be so deeply rewarding that some critics view it as the outcome of 'unconscious strategizing on the therapists part.' He finds this so insidious an accusation that he is 'monitoring his own behaviour with vigilance' to ensure he is not embarked on a 'manipulatory plot' which is aimed at achieving mutuality which may be deeply satisfying for the therapist but quite irrelevant to the client's needs.

(Polarity Therapy offers techniques for direct energetic contact not just verbal and, although the skills and art of the therapist have a large impact, they are not the deciding factor in all cases of success or failure of any particular session.)

POSITIVE ASPECTS OF PCC

• Given the down-side of the non-directive approach, (listed above), at least the client knows his progress is his own doing — he is empowered.

• PCT is frequently applauded for its usefulness in promoting beneficial changes in self-concept although it is criticised at the same time for its failure to change behaviour. (see limitations)

• The person-centred approach can be used in small or large group work, usually with two 'facilitators'. No client is obliged to join a group from the outset — the client decides. Success will depend on the therapist's ability to create an environment in which the members can interact with each other without fear. **On the negative side** - **Family and couples work** is not undertaken without **extensive preparatory work** with each individual on a one-to-one basis. The family process is obviously more complex and time consuming for the therapist hence person—centred family therapy remains comparatively rare. Thorne suggests it is the therapists who select themselves for such work and not the clients who are selected.

• Despite the insistence on the here and now, Thorne contends the PCT approach does allow **space for intuitive input by the therapist.** The more he is able to be present to himself in the therapeutic relationship, the more likely he will come to trust the promptings of a 'deeper and more intuitive level within himself. For him developing trust in intuitive responses is a natural development of the approach. i.e. The more he has entered the client's world (congruence), the more likely such responses will be accurate. (*I see a fine-line between voicing or acting on intuitive responses and being directive which surely is contrary to PCT? —(But Thorne is a PCT expert!)*

When Thorne has risked articulating a thought or feeling which comes from this deeper level he has done so in full knowledge that it may appear unconnected to what is happening in the relationship or even bizarre to the client. More often than not, the client's response has been immediate and sometimes dramatic. "It is the quality of the relationship established with the client that goes a long way to ensuring that the therapist's intuitive promptings are deeply and immediately significant to the client." Often too the significance lies in triggering a past experience for the client in the sense that it is relived releasing a flow of feeling. (**This exemplifies the efficacy of the of water connection**). He has found that the intuitive response ` often touches part of the client's being that cannot find immediate expression in words. —the client reaches out for physical reassurance, plunges into silence or even requests writing or sketching material. (*And that from a process where the emphasis is on words*!)

• I found the following case example of this PCT expert to be an **encouraging final note** in that even, what may seem to the therapist to be, 'alarming backward steps' can be progress. *I forget too easily, when in the midst of such stages in client therapy, that change can often require working through the mire (I had to search for the polite word therel), - that the mire <u>is</u> change. I found this example a positive reminder because I have hit an apparent impasse with some clients and found myself disheartened.*

- Thorne cites a client, Louise, who was 'strong and weak, coping and confused, self-affirming yet craving approval.' - (I can relate to those!) These apparent contradictions gave her no firm identity and made her life intolerable to her. Her sessions with him went through peaks and troughs but he felt the relationship he had built with her enabled her to experiment with the situation; she was able to take risks with it, running out of one session, even experimenting with a suicide attempt. For Thorne, this experience showed in dramatic and moving way, the client knows best even if it means, as in her case, the rejection of coping behaviours and the descent into chaos. "What is more, "my relationship with her showed me that, as a therapist, l can be taken completely by surprise and make apparently profound errors of judgement without losing the privilege of being a faithful companion who goes on trying to be accepting, empathetic and open to the flow of my own experience within a relationship." — *the essence of PCT exemplified!*

MY OBSERVATIONS FROM THE VIDEO of Carl Rogers in action .....

The predominant energy the therapist is using in the case study is watery, reflective, passive, open, yin.

'Content' is the key. lt is vital for the therapist to hear the client's story and remain present in the relationship.

In this relationship the client, Mary, is encouraged to be yang at all times, to lead the therapist who remains yin.

The videod **non directive, client led** approach reveals its positive and negative aspects:-

• As Rogers opens up, inputting how he feels in the relationship, he brings in his own feelings and relevant experiences. This helps Mary with her inner voices. She feels she can open up to him because he 'sounds like he cares'. In this case it helps the client but this could be a hindrance to the client if the therapist becomes too self-absorbed, leading to client frustration, impeding client progress and depleting client's purse! It could also lead to a confused client/therapist relationship of transference and counter—transference.

(As Thorne contends, the limitations of the process reflect the limitations of the individual therapist).

• Mary repeats herself, (stuck in a watery loop). Rogers does not get to the heart of the problem in this session. This short example shows how PCC sessions could go on and on. This method does take longer but the empathy shown by Rogers helps the client feel comfortable and able to stick with him. Mary saw Rogers as the father she would have wanted – this could be unhealthy if protracted; I assume she moved beyond that stage to one of self-worth without the reliance on the approval of a soft, kind father figure. (I noted Mary maintains extended contact with Rogers but not the other therapists in the video).

I was frustrated waiting for some direction, some gentle probing, some fire, from Rogers. Mary too gets frustrated, she wants him to direct her, to give advice. (This would be counter to PCC principles - see previous notes on decision making. The basis of PCT - let the client regain her own power in her own time).

REFERENCES

'Person-centred Therapy' section of 'lntroduction to Psychology', 11th edition, by Atkinson, Atkinson, Smith & Benn, pub. Harcourt, Brace & Jovanovich, 1993

'Person-Centred Counselling in Action' by Dave Mearns & Brian Thorne* pub. Sage 1988 (1995 reprint).

'Person-centred Therapy' by Brian Thorne, being ch. 6 of a psychotherapy book, a photocopy I was given - book source unknown.

(* Director of Student Counselling E. Anglia University)

Appendix 1

Characteristics of a fully functioning person:-

1. Openness to experience

2. Ability to live fully in each moment of one's existence

3. Organismic trusting (best displayed in process of decision-making. I.e. regarding organismic experience as the most valid source of information for deciding what to do in any situation. ...'feels right proves to be trustworthy guide to behaviour'

4. Personal freedom. Responsibility for determining one's own actions and their consequences based on a feeling of freedom and power to chose. No feeling of being imprisoned by circumstances or fate or genetic inheritance, although Rogers does not deny the powerful influences of biological make-up, social forces or past experience.

5. Creativity. Experience oneself as a free agent. Typically creative in sense that he can adjust to changing conditions and likely to produce creative ideas or initiate creative projects. Relate to society in a way that permits them to be fully involved but not imprisoned by convention or tradition.

Appendix 2

Common changes that are perceived to constitute a goal of person centred therapy:-

Clients are perceived to move -

1. Away from facades and in the constant preoccupation with keeping up with appearances

2. Away from 'oughts' and an internalised sense of duty springing from externally imposed obligations

3. Away from living up to the expectations of others

4. Towards valuing honesty and 'realness' of oneself and others

5. Towards valuing the capacity to direct one's own life

6. Towards accepting and valuing oneself and one's feelings whether they are positive or negative

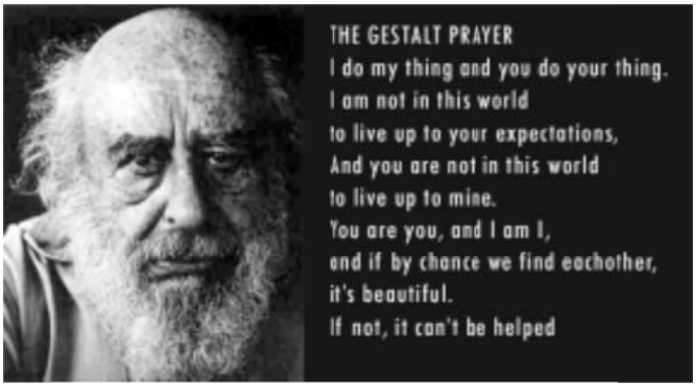
7. Towards valuing the experience of the moment and the process of growth rather than continually striving for objectives

8. Towards a greater respect for and understanding of others

9. Towards a cherishing of close relationships and a longing for more intimacy

10. Towards a valuing of all forms of experience and a willingness to risk being open to all inner and outer experiences however uncongenial or unexpected. (Frick 1971, cited by Thorne)

FRITZ PERLS - GESTALT THERAPY



HISTORICAL DEVELOPMENT

Frederick (Fritz) S. Perls,(1893 -1970), a German born psychiatrist, founded Gestalt therapy in the 1940's with his wife Laura. He was influenced by the psychoanalysts Karen Horney & Wilhelm Reich, also by ideas of **freedom and responsibility, the immediacy of experience and an individual's role in creating meaning in his life** from existentialism and phenomenology.

He was a vital and charismatic person who admitted to many compulsions including smoking and 'leching', (Perls 1969, p.17). His counselling approach strove for responsibility (response-ability). He regarded gestalt counselling as an existential approach. l.e. 'notjust occupied with dealing with symptoms or character structure, but with the total existence of a person'. 'Gestalt therapy is a philosophy that tries to be in harmony, in alignment with everything else, with medicine, with science, with the universe, with what is', ((Perls 1969, p.71).

Perls had a cynical view of his clients' motivation compared with the person-centred belief in the self-actualising tendency of the human organism. " .... roughly 90% don't go to a therapist to be cured, but to be more adequate in their neuroses." (Perls.p79)

Although Gestalt began as a therapy for individuals and groups in 1950's America its therapeutic thrust was also conceived in broader educational terms. Gestalt therapy is '**a humanistic method** of psychotherapy that takes a holistic approach to human experience by stressing individual responsibility and awareness of present psychological and physical needs'; .

(Encyclopaedia Britannica).

Perls rejected atomistic explanations of human psychology that rested heavily on analysis and 'objectivity'. He preferred a more rounded approach, though he was still caught up in the myth of objectivity, and bound to the ideal of verification through research. Many of his techniques have been incorporated into eclectic approaches to psychotherapy.

THEORY/CONCEPTS IN GESTALT THERAPY

According to the Concise Oxford Dictionary, Gestalt means a 'conceived organised whole which is the sum of its parts.' Gestalt psychology provided a framework for Perls' system. According to this psychology of perception, when organisms are confronted with a set of elements, they perceive a whole pattern or configuration, rather than bits and pieces against a background. Gestalt psychology holds that perceptions, reactions etc are gestalts i.e. perceived in terms of

whole units. The human organism is seen as a unified whole, which can only exist in an environmental held. Hence mind-body and person-environment splits are erroneous. Perls objected to the old mind-body split. Human beings are wholes engaged in fantasising play-acting and doing.

Needs

Perls maintained that healthy people organise their field of experience into well-defined needs to which they respond appropriately e.g. if they experience hunger, they eat. A neurotic interferes with the formation of the appropriate Gestalt and does not deal adequately with his need e.g. he may be angry as a response to stimuli but represses awareness of his anger. Gestalt therapy seeks to **resolve the conflicts and ambiguities** that result from the failure to integrate features of the personality.

The goal of Gestalt Therapy is to teach people to become **aware** of significant sensations within themselves and their environment so that they respond fully and reasonably to situations. Gestalt therapy assumes the **innate inclination of individuals to health, wholeness and realisation of their potential**, (*like Polarity Therapy*). The awareness it seeks to cultivate is essential to restoring the natural inclination to happiness and fulfilment.

Life is characterised by a continuous process of balance and imbalance in the organism, with homeostasis being the process whereby the organism satisfies its needs by restoring balance. The human organism is in a state of constant change; no sooner is one gestalt completed than another comes into being. Balance is disturbed either by external factors (demand from the environment) or internal (needs) factors. The organism has psychological and physiological needs. Sometimes several needs are experienced simultaneously, in which case the individual has to attend to the dominant survival and self-actualising need before the others.

Life is basically an infinite number of unfinished situations or incomplete gestalts. The contact boundary is the boundary between organism and environment and it is here that psychological events take place. **Health** involves identifying with ones forming organismic self and keeping in touch with ones senses.

• **Gestalt (experiential) experiment.**

When chewing food, notice how you eat it. Do you chew in hard bites or more slowly? Do you swallow lumps barely masticated? What contact do you allow between the food and your mouth? How much taste of your food do you have? Repeat the experiment- really chew l and taste, savour every morsel, chew till liquefied then swallow.

In the above experiment, the unconscious - that which we have forgotten - plays a part at the point we begin to liquefy the food. People resist, become bored, they say they have no time to eat this way and often feel sick if they pursue it. What is going on?

In Gestalt, neurotic behaviour is likened to a needle stuck on a record. The therapist's task is to help the needle jump out of the groove and complete the tune. (*This can be likened to the watery loop of behaviour patterns in Polarity Therapy*). The situation is complicated by the fact that neither therapist nor client knows the tune awaiting completion. Also the client has usually forgotten how he got stuck and fights shy of how he might be repeating the pattern right now. Remembering ourselves involves taking risks. The Gestalt therapist offers a context in which we can do this.

• **Going back to the experiment:** :- The Gestaltist would ask 'What was bad about the food that made you nauseous? What did the liquid remind you of? Are there any associated fantasies or images? Did you stop the images as they arose? Why? Embarrassed? Why? Did you criticise yourself for having the fantasies/feelings etc? Why?

All these are **'interruptions' or 'disturbances' to the process**. These disturbances **prevent deeper more genuine contact with life as it is.**

Our capacity for self- support is often interrupted by others in childhood, causing us to suppress emotions. The gestalt therapist provides frustrations to these habitual interruptions to mobilise our latent resources. Between the self zone and the outer zone is 'maya' or fantasy activity. In neurosis there is a continuous fight between fantasy and reality - this applies to most of us. Gestalt therapy uses techniques to elicit fantasies for the client to confront them for what they are - fantasies!

Categories of interruptions

According to the Gestalt Therapy theory, the 4 main neurotic mechanisms, (or contact boundary disturbances), are **introjection, projection, retroflection and confluence**. Each interruptive process has a creative as well as a neurotic aspect- (*polarity*). NB They are descriptions of process not types of people. We all behave in these ways at different times, but some of us will have a bias to one type of behaviour.

Confluence

(Literally 'the joining of two rivers') is a normal event .eg. Lovers loose themselves in each other when making love; with a good book or an exciting film we can identify with the characters or ideas being conveyed. The ability to identify is needed in some circumstances; (*especially for the therapist- see Person-centred therapy notes*). Confluence is a neurotic behaviour when it comes from a fear of difference which has become habitual and ingrained. Then the individual lacks any distinction or experiences no boundary at all between self and environment. Since he is unaware of the contact boundaries between self and others, such people cannot make contact with others or withdraw where appropriate. A feature of confluence is demanding likeness and refusal to tolerate differences. E.g. refusal to see spouse or children as different from oneself.

Introjection

The process whereby we take in rules. As adults we have the power to select rules by which we want to live. As children we may become rule bound*, (ref PCT notes earlier*) - 'indiscriminate swallowing of rules can lead to indigestion'. Common rules we all share in some form surround sex and anger in our society. Introjection is swallowing whole outside material rather than assimilating the valuable elements and discarding the toxic elements. The result is undigested thoughts, feelings, behaviour etc.

Projection

Projection is the reverse — i.e. to own as part of the environment what is actually part of the self. The capacity to see in the world that which is contained in ourselves is a valuable potential; without it we have no visionaries, such as the Greenpeace movement, let alone the capacity to plan ahead. But in neurotic behaviour there is a refusal to acknowledge that what is out there is also part of myself. It is very common and hence the best known psychological phenomenon, i.e. shifting those parts of ourselves that we dislike and devalue on to others rather than recognising and dealing with these tendencies in ourselves.

E.g. the habitual projector will say 'you are angry with me' when he wants to say 'I am angry with you'. Or he will give anger an objective existence outside of himself, 'it took control of me' so he can make it responsible for his trouble and avoid full recognition that it is a part of himself.

(*I feel that projection can be helpful in the initial stages of therapy to help the client move away from guilt or low self-esteem. In polarity therapy I am continually objectifying emotions as 'the energy moving' to help the client get some perspective or space/distance from them to help the healing process).*

Projections are associated with introjects because people usually devalue themselves in relation introjected self-standards e.g. parents' ideas of 'a nice young man' etc.

Retroflection

Turning back to the source energy which was originally destined to go out from that source. Here individuals fail to discriminate between self and others accurately by treating themselves the way they originally wanted to treat others. They redirect their activity inward and substitute themselves instead of the environment as target, in the way a harassed mum might turn her destructive impulses on herself. Retroflection, is not necessarily neurotic. It might be to the person's particular advantage to suppress particular responses at times but it is pathological when habitual and out of control. (e.g. self abusers)

E.g. Holding your tongue, if not doing so is likely to lead to violence, would seem to be sensible. Or Blaming myself for my shortcomings where it is easier to say it is my fault than take the risk of being aggressive. (*But we have to beware of building up habits and future problems — i.e. motivation is the key).*

Egotism

Here the ego becomes king. It is characterised by a wall of words, rational explanations and commentaries which prevent the experience of deep feeling. Again, as with the other interruption processes, such behaviour can be creative, we do not always wish to share deeply - (*discernment is the key)*

Perls was **sensitive to the use of language in representing and sustaining boundary disturbances.** e.g. In introjection the 'I' is used meaning 'they'; in projection 'they' or 'it' are used when the real meaning is 'I'; in confluence 'we' is used when there may really be differentness and in retroflection 'myself" is used reflectively as in 'I am ashamed of myself.

In **neurotic behaviour** there is no flexibility. Any challenge to the system that maintains the neurosis is experienced as a threat, even life threatening.

• E.g. Pointing out someone's habitual cough or clipped speech is received as an attack on the person, rather than being perceived as useful information in the process of getting to know oneself. Energy is transferred to the 'interruption' and away from the real source of discomfort and disease. This is very common; *(I know I have felt 'injured' by criticism*). It is the skill of the therapist, of whatever school or practice, to maintain the balance between 'safe' and challenging context.

THE GESTALT COUNSELLING METHOD

It is primarily an EXPERIENTIAL FORM OF THERAPY.

The **focus is on the here and now**, rather than the past, although once the client becomes aware of the present he can confront past conflicts or unfinished business — what Perls called 'unfinished GestaIts' - (i.e. work through the layers). Clients are urged to discuss their memories and concerns in the present tense and **remain senses focussed**, i.e. not to 'explain' these concerns away. (*I guess the therapist could use manipulation of time-lines here to bring the client's past into present awareness*).

The Gestalt counsellor provides a context for the client to process his unfinished Gestalts. The counsellor must not explain or interpret.

Fritz Perls believed an **aggressive attitude** towards experience is necessary if it is to be destructured and then assimilated as one's own. This lead to his style of **providing frustrations** so his clients would mobilise their own resources to manipulate the environment. The Gestalt counsellor will draw attention to the client's behaviours. This is likely to be embarrassing for the client. The counsellor **risks producing reactions** that obscure the real difficulty because-

1. Experienced therapists find avoidance of core pain in therapy is inevitable. None of us wish to suffer but we do not grow unless we do. Simple desire to change does not mean we are ready or able to face the real hurt or difficulty our lives are built on. Some never will. So people use every skill to avoid seeing themselves as they really are till they are ready.

2. Confrontation is therapy. **Gestalt is a confronting form of therapy in that it offers observations that are difficult to deny**. We can both see that your legs are crossed, you can feel your face is hot, I can see it is pink, I can hear the tone of your voice. We both know instinctively that such feedback is pertinent. The more it disturbs us the more pertinent it is, from the point of view of therapy.

Although it is a confronting method, a good Gestaltist will temper those skills with understanding of what someone is capable of handling. He is trained to be sensitive to the quality of contact he receives from his environment- he can sense the 'no', however subtle. He will not plod on with the present agenda but work with the discomfort and disinclination to continue. i.e. He will work with the interruption by asking such questions as 'What is it you are afraid of?', using traditional skills of identification and empathy, drawing on personal resources of sensitivity and compassion and using respect for integrity of others.

Perls required six elements for his 'performance'. .....

"1) My skill, 2) Kleenex, 3) The hot seat 4) the empty chair, 5) cigarettes, 6) an ashtray" (Perls, p.227). He viewed all counselling sessions as experimental, in that counsellors need to try things out to help clients become aware of how they are functioning now as organisms. Sometimes he did mass experiments, even favouring conducting counselling in workshops which included communal baths! He mostly worked with a series of single people or sometimes couples in front of the group. His methods hinge on uestions when, with whom and in what situation.

Change involves focusing on how the clients' contact boundary is being disturbed in the present moment.

Gestalt approaches to counselling practice include the awareness technique, sympathy and frustration, eliciting fantasies, drama techniques, dreamwork and various rules and games.

Awareness Technique

Gestalt counselling is experiential rather than a verbal or interpretative approach. It demands that clients experience themselves as fully as possible in the here and now, both to understand their present manipulations and contact boundary disturbances and to re-experience the unfinished business of past problems and traumas. Emphasis on 'now' keeps client and counsellor in the present and reinforces the fact that experience can only take place in the present. Awareness always takes place in the present and opens up possibilities for action. Clients are asked to be aware of their body language, breathing, voice quality and emotions as much as of any pressing thoughts. (*As in above experiment*).

• E.g.(film series Three Approaches to Psychotherapy- Dolliver 1991, p.299)

What are you doing with your feet now?

Are you aware of your smile?

You didn't squirm for the last minute?

Are you aware your eyes are moist?

Awareness technique is **a concentration technique**. It brings the client to an awareness of his constant self-interruption of his contact with himself and the world, also of what he is interrupting and how (i.e. through the neurotic mechanisms of introjection, projection etc.) Clients were also given **homework** which consisted of reviewing the session in terms of systematic application of the awareness technique.

Sympathy and frustration

A combination of sympathy and frustration is needed as 'sympathy alone spoils the client': (*with empathy the counsellor is in danger of allowing confluence*). Clients must be frustrated in their efforts to control the counsellor by neurotic manipulations and instead learn to use their powers of manipulation to meet their real needs. The counsellor focuses on getting the client to become more aware and not become phobic when he starts feeling uncomfortable.

Perls provided situations in which his clients experienced being stuck in frustration and then frustrated their avoidances still further until they were willing to mobilise their own resources. (*Pushing to the limit- rajasic, or digging to the depth —tamasic.*) He frustrated them till they were face to face with their blocks, inhibitions and ways of avoiding having eyes, ears, muscles, authority and security in themselves.' (Chpt.3,p.59)

Frustration often leads to the discovery that the phobic impasse does not exist in reality. Furthermore, frustration helps clients to express their needs and requests directly rather then cover them with neurotic manipulations. "The imperative is the primary form of communication and clients who can state what they need and mean what they state have made the most important step in their counselling.",(Chpt.3,p.59). *Ref also Caroline Myss - 'people keep coming to my workshops because they are afraid of their own power".*

Eliciting Fantasies

This technique is used to speed up the slowness of the awareness technique. Perls made considerable use of fantasising whether verbal, written or acted out. ..

. • e.g. (Dolliver film series, p300 - refd. Chpt.3) Gloria is asked to describe a fantasy-

'Can you describe the corner you'd like to go to? Imagine you are in this corner and you are perfectly safe. Now what would you do in that corner?'

Perls also asked Gloria to describe her fantasies about him.

'How old must I be? (for Gloria to scold him).

'How should I be? Give me a fantasy. How could I show my concern for you'?'

Dolliver observes that whenever Gloria offered Perls feedback about her experience of him, Perls regarded it as a transference fantasy representing her projected attributes.

Drama Techniques

Dramatising conflicts is also a method Gestalt therapists use, getting clients to act out repressed aspects of their personalities or adopt the role of other individuals. In **monotherapy,** (monodrama), the client is in control; he creates his own stage and plays all the roles under his own direction and expression. The client is asked to **shuttle** his attention from one area to another. e.g. Shuttle between the visualisation of the memory and the organismic experience of reliving it here and now; shuttle between talking and listening to himself.

The purpose here is to help clients stop compulsive talking which interrupts their experiencing of themselves and their environment. Drama and fantasy can involve '**the hot seat'** and 'the **empty chair'**. The hot seat is the chair occupied by the client in front of a group, the empty chair is a projection-identification gimmick to be filled by fantasised people and things. It is a method of highlighting the shuttling process by getting client to change chairs as he shuttles between parts of himself or between different people in the drama. **Clients can also shuttle between the controller** (topdog, super ego) **and underdog,** (controlled, intra ego). i.e. Between the righteous, perfectionist, authoritarian, full of shoulds and should nots that manipulates with threats of catastrophe if his demands are not carried out and the cunning underdog who manipulates by being defensive, apologetic etc - e.g. 'I try my best, I have good intentions'

By shuttling between these 2 polarities clients are helped to understand the structure of their behaviour and to effect a reconciliation between them by becoming more in touch with their organismic selves.

Dreamwork

Perls saw dreams as 'the royal road to integration'. They bring essential messages, especially if repetitive. He encouraged the client to relate the dream, make it present and act it out.

GOALS IN GESTALT THERAPY

A Gestalt therapist's task is completed when he succeeds in providing a context in which the client can move on and finish the 'tune'. The repetition of past problems loses its hold and the client effectively says 'I'm going to risk doing something new.' For most, such awareness of what is possible, comes gradually with **repeated** approaches to the difficult area because the area is bound up with so much emotion. Eventually we get to the 'aha, now I understand' stage. "That old business that seemed so important before, dissolves and the present resonates with clarity and joy." (book ref.)

Goals for counselling include **self-support** rather than environmental support, **being in touch** with one's senses and existential centre, **self-actualising** rather than self-image actualising, **responsibility or freedom of choice** and the ability to **form and close strong gestalts**.

Gestalt therapists assist the clients to support themselves not only in solving current problems but also in living more authentically. lt has been said that the only goal of gestalt counselling is **awareness.** Clients require awareness of particular areas and also of the processes or habits by which they block awareness.

The process of **self actualising** involves 'an effective balance of contact and withdrawal at the contact boundary and the ability to use energy, or 'excitement', to meet real rather than phoney ' needs.' Also self-actualising involves being able to withstand frustration, whether provided by the therapist or life events, till a solution emerges.

ln Gestalt jargon...self-supporting, healthy people are able to appropriately use aggression to assimilate their experiences and are largely free from the neurotic contact boundary disturbances of **introjection, projection, retroflection and confluence**. They possess relatively little self-destructive unfinished business since they are good at forming and closing strong gestalts. i.e. *In polarity terms, they have few energy blockages.*

POINTS OF CRITICISM - (GENERAL AND FROM VIDEO)

LIMITATIONS OF THE APPROACH

• These techniques of manipulation and frustration of the client could add to his pain and stress. This challenging approach might be too fiery, too aggressive, too much 'in your face' for some clients. The client in the video got defensive; she did not want to explain. She verbally attacked Perls, accusing him of demanding respect, of being 'phoney':- "You don't really care. You are full of your own importance." (*Although this was uncomfortable for me to witness, this was a breakthrough in the therapeutic process on a gestalt basis as this client's response was real, direct and present*.)

• Gestalt therapy is preoccupied with how we meet and the quality of that meeting — i.e. in gestalt jargon — 'the contact and the process of the contact'. It is senses focussed to the point of denial of the spiritual aspect of the human being and so is **not truly holistic**. It concerns itself with psychological and physiological needs only. It is primarily an experiential form of therapy.

Humphreys argues that Gestalt therapy has '**little place for the word soul or the idea of the unconscious.**' (ref. P.11). It also generally leaves out the spiritual and intellectual contributions that we make to human life.

Gestalt, in its original form, rests firmly on western scientific assumptions about the world. i.e. Only that which we can feel or experience empirically is deemed worthy of attention. It stands philosophically in the existential tradition — one is perceived as standing alone against an alien universe and we have to create meaning or perish. Gestalt's relationship to the unconscious mind is limited: the unconscious is only relevant in so far as it is affecting contact.

Humphreys is concerned that psychotherapy, whatever school, should heal souls and contribute to the growth of humanity. (*Certainly I feel my work is more rewarding for my client and me when we meet at the spiritual level- but I let that occur naturally, I do not force it.)* He feels that although Gestaltists may argue they do not deny spirituality, the one they accept is 'an individualised, customised spirituality that takes no serious account of its purposes, which is to promote harmony between people.'

'It is paradoxical that, in Gestalt, **relationship*** is encouraged growth, which means relationship is seen as vital, as too is the ebb and flow of relationship — seen correctly as an organic phenomenon. But the soul, which is the foundation of our collective connectedness with everyone is denied and so are any practical consequences for changing society.' (* *my emphasis*)

• Because analysis and explanation are not allowed to play a part in the therapy, **intellect is another aspect of human life that is denied in Gestalt**. It can be argued that the intellect is the only tool we have for 'finally wresting from the unconscious what is our heritage'. 'Gestalt does itself a disservice by excluding it as it is by no means clear that 'good contact' cannot be furthered by acceptance of the client's intellectualism.

• The air element is denied access in the Gestalt counselling in so far as the client cannot bring in ideas or the broader picture. But he can bring past issues in by reliving them i.e. bringing them into the here and now.

• In this fiery approach, the therapist will challenge and frustrate but not analyse or advise the client. Some clients want some advice, that is why they come to the therapist, the 'expert'.

POSITIVE ASPECTS

• Gestalt therapy made a real contribution to psychotherapy technique being the first to really break into feeling work seriously. The techniques it introduced gave the therapist a more active role in healing, based on the premise that it is through action that change and growth occur not through wordiness or intellectualism.

• This fiery approach encourages the client to take risks thus empowering him. In Gestalt therapy the client should discover himself by himself. He then has no need to rely on the therapist, but can get on with his life.

• No manipulation of the environment is tolerated and the 'watery loop' is not indulged as the client is forced to face the moment, remain present with full awareness and push through the energy blockage. lt is through **awareness** that we can change.

• The therapist's reference to the client's body language keeps him in the present. (Body language comes from the frontal Conscious Associational Thinking area of both the dominant and alternative brain. The CAT holds newly acquired, non-conditioned knowledge so is more genuine and present.)

(*Apparently Gestalt therapy has changed, adopting softer materialistic values*).

Recent Gestalt counselling developments include less emphasis on frustrating clients, more counsellor self- disclosure and use of psychoanalytic formulations to describe character structure i.e. less 'in your face' and intrusive.

• My observation from the video:- I felt the client had more insights to her problems by the end of the session with this method than with the Person Centred Session.

REFERENCES

'Gestalt _Psychotherapy' article by Vincent Humphreys from the series 'Groping beyond the Growth Movement' in the journal 'Psychotherapy in Ireland'

'Gestalt Counselling', Chpt. 3 of book 'The Theory and Practice of Counselling', publication details not available but author's main source for this chapter is given as the two volume work 'Gestalt Therapy' by F.S. Perls, R.F. Hefferline & P. Goodman, published Souvenir Press 1951.

Encyclopaedia Britannica

MY APPROACH TO THE COMMUNICATION ASPECT OF POLARITY THERAPY

The Dance

For me the communication aspect is a two-way flow, (involution and evolution it you like); mind energy flows through verbal and body expression. It is a 'dance' performed by the client and me, sometimes I provide the outflow (positive pole) and he receives, (negative pole) — I wait for the return flow from the client and in turn respond. There is no strict timing or choreographed steps for either performer but it is up to me to see he doesn't go way off the dance floor, dance us both off our feet or go on beyond the time for 'the fat lady to sing'. By and large the pace is set by the client- at least at first, so he can feel I am not going to tread on his toes or be too pushy. There is no point in me pushing him into a foxtrot when he only knows the waltz; I need to let him see (what small easy changes he can make in his step to change his tempo and how great it feels when he does.

Before I get too carried away with this analogy ....

Even in the initial, 'getting to know the client' stages, the positive and negative roles, (yang and yin), change. Although I am mostly the recipient, listening and watching the client for verbal and body language clues to his current state of energy flow and location of blockages, (physical, mental and emotional), the client wants some output, some information, from me. This is usually in the form of what polarity therapy entails and how it can help his condition. I am always positive at the start so I can set the scene for how it should continue, i.e. positive affirmation/expectation — although I am careful, I hope, not to make outlandish or false claims.

The communication process is basically LISTEN - RECEIVE/DIGEST - RESPOND for both the client and myself. This process, dance, goes on throughout the session on and off the couch. I take in his messages, decide what they mean, or more likely might mean, and what action I need to take and respond whether it is with therapeutic touch, ideas, advice or silence/space. In his turn, the client's healthy required response might not necessarily be to me but to or with someone or some aspect of his life, behaviour etc. Sometimes there is no response from the client, no 'return flow', in which case I have to change my message!

First Steps

The communication and therapeutic process starts at the stage of making the appointment, which might only provide verbal contact and exchange. Some of my treatments are impromptu ones for yoga clients on a one-to-one basis at Stobo Health Spa or Carstairs State Hospital, but the information gathering, energy receiving aspect of the pre treatment communication is the same. On these occasions I don't have the benefit of time or paperwork to make a comprehensive case history.

At this getting-to-know-you stage it is vital that the client is relaxed. I explain briefly my need to make a few notes. I try to do so unobtrusively, using quick notes, jots and squiggles on my prepared forms as most of my awareness needs to be in listening and watching. The note-taking helps to reassure clients that Polarity Therapy is not an airy fairy but a bona fide therapy. I have to remain open, non-directive so I can get as much of the picture as possible, all the clues, verbal etc. As I listen I have to be careful not jump to conclusions or to interpret too soon. It is the same when we get to the couch. Although I might have particular sessions or contacts in mind, often the energy released in the first 10 minutes leads me elsewhere.

I have learnt the hard way not to let the client ramble with his history for too long. (In the **most extreme case**, the session spanned 3 3/4 hours, at least 2 of that was the client's monologue in language I could not follow. I realised

afterwards that I had been on the receiving end of 'stream of consciousness talking'. Her propensity for the verbal aspect of therapy, rather than the tactile, had been previously encouraged by 10 or more sessions with a psychotherapist. She had learned and used the psychotherapy jargon, which was foreign to me and made it even harder for me to connect with her. Now that I have battled with the PCT and Gestalt essays, I reckon I'II be better prepared. *Although Phil has guided me to get such clients to the body work I as soon as possible as they have already done the talking therapy bit and need to get out of that watery loop and into an unfamiliar approach to shift the blockage. I finally got her to shut up half way through session two, (yes she babbled away on the couch too)*, with perineal floor contacts. Although I saw changes in her, she cancelled session 4 and I have not seen her since.)

The flow of the dance

The exchange of energy is kept flowing by relating to the client in the positive aspects of both yin and yang in communication as I must be able to lead and be lead; I must be his polarity.

YIN —

- Be the mirror for the client, give a clear reflection but be kind as well as true; be content, do not nag the client, be aware of the power of the therapist position; be open but beware of transference. Be empathetic, i.e. identify with the client but do not loose your own identity.
- Don't get overemotional - the old question arises of who is benefiting from the therapy?
- Do not lose your own energy by doing too much for the client, let him be responsible for his own health.
- Attract- be a magnet of life
- Select — the appropriate therapeutic approach
- Support - the client

YANG — ·

- Act, listen, watch for feedback, look at the feedback and respond.
- Be aware of your limits. Be decisive but not overly forceful- do not dither.
- Give time, do not interrupt, allow the client to find his own truth/action in his own energy flow but don't let it flow on aimlessly, see example above! Yes, polarity therapy is client-led but verbal communication may only take us up to a point, we do have body-work, nutrition and exercises to influence client well-being.
- Be able to let go and not worry if the client doesn't come back; do not get upset/angry if his condition does not improve — maintain equanimity. (This is an area I still have a problem with re. guilt and sense of inadequacy).

COMMUNICATION AND ENERGY TYPE —

(Details and examples in Rapport essay p.4-6)

The therapist should be able to dance with all the elements in communication, i.e. Be aware of what energy the client is communicating with and respond appropriately. Be aware of what energy you are communicating with and of what effect that might have on the client.

Mind

The master matrix of our energetic being is held deep in the unconscious mind.

In the communication aspect of Polarity Therapy we are engaging the client's mind to help raise his awareness of his patterns of communication with the world and with himself- (his verbal & body language patterns, his patterns of internal dialogue & pain avoiding strategies). This move to **awareness** is the key; he has to step outside the unconscious patterns in order not to be controlled by them. *Because life energy forms the link between mind and body we can resolve emotional and physical disturbances with bodywork — i.e. we do not have to rely on mindwork in Polarity Therapy.*

We all have to be acquainted with energy in our body and realise energy is consciousness itself; consciousness is intelligent vibration. I give the client some explanation of the mind-body connection, the relationship between physical pain and mental 'dis'-ease as energy blockages. But I do watch how I express this mind body unity to those new to this concept or those who (might misinterpret and blame themselves for their illness, i.e. feel 'my mind is causing everything'.

It is important to use positive reinforcement, give the client techniques for developing positive thoughts and attitudes to influence the mind/body. Positive attitudes like gratitude and love are a good start and end to the day. — *There is a useful Louise Hay audiotape for this.*

Transmitting energy to the past by dwelling on painful events drains power from the present day body and leads to illness. I can appreciate the mental ease given by shifting past events with a current charge into the client's past spatial location, (ref. Time Lines) but have not used this technique yet.

Charges

Just as in the bodywork you increase energy to the blocked area to shift the block, in communication you can find similar resonances and 'press on it'. You find where there is energy and increase it. (e.g. Get the client to talk about what gave him a buzz as a kid to shift his current state of inertia). Watch body language for a 'charge' on any topic discussed. Charges are only in the present; therefore if it is a past issue you can shift it to the client's past time spatial location, (time lines).

Ask about related beliefs. e.g. Attitudes to food & eating habits if there seems to be a charge on any discussion on sex, (i.e. fire & passion link, sensual aspect of eating).

Using the 5 senses (pre, during and post body work)

LISTEN

For the energy of the voice tone, for the words that are emphasised, for any constriction and to the actual words used. I have had many clues from client's words. *E. g. Recently one client described what I sensed as a fiery release in her lower right abdomen as ' itching. From no-where, I guess because I was 'in her space' and open, I found myself asking "Is there something you are itching to do?" There followed a verbal and emotional release of issues she had not mentioned, perhaps not even been aware of in her previous 4 successful sessions.*

I am learning to be aware of the use of language in representing and sustaining clients' 'boundary disturbances'. e.g. In introjection 'I' meaning 'they'; in projection 'they' or 'it' meaning 'I'; in confluence 'we' is used when there may really be differentness.

There is a therapeutic benefit for the client to hear himself say aloud, express, some feeling he has been denying.

TOUCH

The main sense for me so far. As well as on the couch I use it before or after sessions as appropriate. i.e. An encouraging, consoling or loving, spontaneous touch.

WATCH

Structure always reflects the energy. Self-image is shown in body and body awareness. Body

language is simpler, clearer and more in the present than verbal communication & much more likely to reflect true feelings. This is because physical expression is generally a function of the frontal Conscious Associated Thinking area of both the dominant and alternative brain, which freely responds to current sensations directly. Whereas verbal skills are held mainly in the rear and in the dominant half of the brain, (Common Integrative Areas), where earlier conditioned survival skills reside. (Of course some people have learned about body language and have the skill of mirroring and presenting a stance, which they feel, is appropriate to the situation but that cannot be maintained for long - even by the most practised self-image makers! This is why it is not the first impression that the client gives that I take - I let them get relaxed and communicate with the real them.)

In my turn, as therapist, I can convey with my body language my willingness to be involved. The eyes for example can express a wide range of feeling — *and yes I have cried with clients*. If you are transparent enough there is little need for verbal communication at poignant moments.

TASTE

A I do not use, apart from when the client and I usually share a cup of tea after the session!

SMELL

The odour of imbalances in energy. This is not a sense I have have tuned yet: I occasionally have been aware of singeing and earthy, faecal smells, a couple of time with a client on the couch but more often from myself whilst lying alone in bed and letting energy move with awareness.

Verbal tactics

This includes sometimes restating a problem the client has in a different way to give him the opportunity to look at it and react to it differently and so go through the block or get out of the watery loop. This might even be in the form of a 'throw away' suggestion; i.e. sewing a seed and moving on to leave him to work with it in his own time. The 'homework' requests and instructions I give are more definite than this.

I am not conscious of using such precise, scientific techniques as 'meta questioning'. I tend to naturally use a filter approach, starting with general open questions around the problem, following through with more specific, probing and reflective responses as appropriate to get to the 'nitty gritty. By 'reflective' I mean repeating what the client said to check I understood correctly.

e. g. Tell me about ....

What, when, who, how? etc

Are you saying, <u>every</u> time you see your father-in-law you get a rash?

This is to avoid the ambiguity of verbal communication leading to the problem —

" I know you believe you understand what you think I said but I am not sure you realise that what you heard is not what I meant!"

lf the client uses comments beginning 'I should' or 'I am'.. etc I tend to probe with 'Whose voice is that? Who says you are/should?' to get back to the root of the value judgement. **If I was to draw a comparison between my 'counselling' style and the traditional Gestalt and PCT methods .....**

I would say these are both narrower, limited approaches. Polarity Therapy has taught me to 'see-saw'. I can be positive to the client's negative attitude, even negative to their positive if required, (e.g. beIow*), i.e. polarise, neutralise and move the client's energy on. I can be watery or fiery, even airy to divert client from the track he is on. I am <u>generally</u> more interventionist than a person-centred counsellor is but less challenging than gestalt practitioners. I do challenge my clients if l feel prompted but I hope I do so with compassion and respect for their integrity.

**e.g. l learned from Phil that sometimes countering the client's positive expectation, i.e. encouraging a relapse, is a therapeutic option. One of my clients - Kate - seems to deliberately sabotage her improvement by setting out to prove me wrong. On reflection I realised she had done this already with an acupuncturist and physiotherapist. She improves after session one as she is caught off guard with the new therapy but once she gets into the way of the therapy she seems to unconsciously deny any benefit and even undo the healing new habits she had adopted. For her, should she return, I now know to tell her to expect a relapse on the understanding she will then set out to prove me wrong and allow the energy to flow.*

<u>Verbal versus tactile communication</u>

It is important to me that the client experiences the bodywork so I get him on the couch as soon as appropriate. I feel he can relax better there and be 'cared for' - the essence of therapy. I find I it easier to feel compassion, unconditional love, for client when I am at the hands-on, rather than at the verbal stages as my mind interrupts less; also I am more directly in the client's space/energy/world.

<u>Therapist qualities and skills for effective communication - personal notes</u>

• The process of **effective communication** is a matter of resonance and establishing **rapport** with **pacing, matching and mirroring** as appropriate right from the start. (These have been covered in detail in the 'Rapport Essay').

• I try to keep coming back to the **qualities of ether**, both in the body—work and in the verbal interaction to keep me in the right space, to stop my monkey mind from interfering and to provide the right space for the free flow of the clients energy. The qualities are **stillness, harmony, balance and spaciousness which bring universal love, neutrality and humility**. The ether element facilitates the flow of **intuition**, which I am slowly learning to i trust. More often than not it comes from an impassioned desperate mental plea from me for guidance as I struggle to 'know' what step to take next with the client. If I come back to ether I know when not to talk, to give the client space.

• We also have to communicate with the client at his level of consciousness. If we express understanding at too deep a level, e.g. voice what for him are unconscious motivations, we might frighten the client away. (*Rogers described such a*

*blunder as 'blitz therapy'). i.e. be where they are, not too far too soon. Again this is a matter of **rapport** and being in the client's world.*

• I agree that the **key attributes and skills of a good 'counsellor' are compassion, empathy, genuineness, openness and honesty**. (Covered in detail in the 'Counselling' and 'Rapport' essays). Most of these require a regular good hard look at oneself and are an ongoing developmental process. For example a broad experience of life facilitates empathy; we cannot be genuine to others unless we are honest with ourselves for which we need to know ourselves; we cannot feel compassion for each other unless we can be compassionate with ourselves. All this is hard work and it never ends!

• Regarding **total acceptance** - One of my clients asked me what I do if I have a client l do not like. I have not had that 'problem' and I know it should not arise if I work at all the above qualities. I have felt despondent and frustrated with client progress at times but usually blame my inadequacy- I know this is an unhealthy, negative response and that I need to appreciate more the client's responsibility for his health. (Theory and practice in a lot of areas have yet to mesh for me). I have found sweaty feet a barrier to fully entering the client's world on a few occasions!

• Further on the matter of total acceptance of the client as he is now, not of the person he might become — **One of the saddest facts** I am working with is that it is easier for me to feel compassion, be non-judgemental and come from the space of ether with my clients than with family and, to some extent, close friends. Despite the best of intentions, I seem to jump in with one of my conditioned responses when it comes to communicating with my daughter and sometimes with my husband. I believe part of that is because I feel responsible for my daughter's energy state. Reading so much during this course about parental conditioning and the impact of the energy of the home-life on children has done much to lay an even heavier sense of responsibility on me than I already felt.

• **Regarding honesty** - I could be kidding myself that I would still feel compassion for the guys in the state mental hospital, who I sometimes treat, if I knew what they had done to be incarcerated there.

I feel that clients want me to communicate with them as a human, with my own foibles and t problems. But to repeat a point from my PCT essay - '**although clients need to experience their therapists' essential humanity and to feel their emotional involvement, they do not need to have all the therapists' feelings and thoughts thrust down their throats.'**

• I can equally appreciate the value of the **protection of professional impersonality**. I would apply it if necessary at such times as the client becoming too reliant on me or in a serious case of transference on the part of the client.

It seems we carry our Polarity Therapy skills everywhere we go, in that we <u>are</u> what we do, so the communication work never stops, we get plenty of practice.