Chapter 6
Person-Centered Therapy: The Case of Tommy

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Introduction to the Person-Centered Approach

History and Theory Development

Grounded in humanistic psychology, person-centered therapy was developed during the 1940s and 1950s as an alternative to the behavioral and psychodynamic forms of treatment that dominated the field at the time. Carl Rogers, Abraham Maslow, and Rollo May were motivated by their concern about the devaluing of the person in therapies where the clinician was positioned in the role of expert. Although the client set treatment goals and had the ultimate responsibility to achieve behavioral change, it was also true that the client was encouraged to follow the lead of the clinician in these existing therapies (Bankart, 1997; Merrill, 2013).

In the early 1940s, Rogers credited others for their work in developing a new approach to psychotherapy, but he was really the first to clearly articulate a hypothesis about human growth and personality change that was radically different from the other commonly used approaches of the time (Kirschenbaum, 2004). Rogers theorized that clients have within themselves important capabilities including the capacity to understand the aspects of life that are causing distress and the ability to reorganize the self in the direction of self-actualization in such a way as to increase internal comfort. Therefore, the function of the clinician is to create a space where these strengths become apparent to clients, leading to the effective use of these strengths (Clay, 2002; Maslow, 1968; Rogers, 1950). He described this clinical work as *nondirective counseling.*

Distinctly different from the directive and interpretive approaches of the time, Rogers chose to minimize the power of the therapist and instead reinforce the inherent power of the client. He saw the clinician's role as helping the client clarify

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feelings with the goal of improving self-concept (Bozarth, Zimring, & Tausch, 2002). This nondirective therapeutic relationship included two experts, the clinician as expert of the theories and techniques of therapy, and the client as the expert of self (Ackerman, 2020).

Rogers created this nondirective therapeutic space by totally avoiding the use of questions, persuasion, diagnosis, interpretation, suggestions, advice-giving, or other directive techniques. In addition, he noted that diagnostic concepts and procedures were often inadequate, reflected prejudice, and were sometimes misused by clinicians. Instead, Rogers' techniques were mainly the use of reflection and clarification of the clients' verbal and nonverbal communication. This acceptance and reflection of feelings created the safe space for deeper exploration by mirroring the client's own experience, leading to increased insight and positive action (Corey, 2009; Kirschenbaum, 2004).

During the 1950s, Rogers renamed his approach *client-centered therapy*. He did so to emphasize the lived experience of the client rather than the nondirective methods used by the therapist. During this time period, Rogers shifted from the clarification of the client's feelings to a focus on the client's internal frame of reference. Rogers recognized that the essential motivator that facilitates change occurs within the client and is mobilized by the warmth and acceptance of the person-centered therapist (Bohart & Watson, 2020; Seligman, 2006). During this time, he also conducted extensive research that provided strong evidence for the value of the therapeutic relationship and the client's resourcefulness as the foundation for successful therapy (Bozarth et al., 2002; Corey, 2009).

The third stage of development, which began in the late 1950s addressed the necessary and sufficient conditions for therapy. Rogers described the process of "becoming one's experience" as an openness to and trust in one's experience, an internal locus of evaluation, and the willingness to be in the process (Rogers, 1961). His research focused on the core conditions that he found necessary for successful therapy. The therapist's attitude and empathic understanding of the client and the therapist's genuineness and nonjudgmental stance were all found to be essential to a positive therapeutic outcome (Bozarth et al., 2002).

Key Terms and Concepts

The person-centered therapeutic process incorporates the concepts of meaning, values, freedom, tragedy, personal responsibility, human potential, spirituality, and self-actualization into its holistic approach to human existence (Aanstoos, Serlin, & Greening, 2000). Recognizing the applicability of the client-centered approach, Rogers and his colleagues began using a broader term, *person-centered,* to describe their work. This term refers to a theoretical view of the nature of human beings and their interactions, and to a philosophy of how to relate to human beings in growth-producing ways, both inside and outside of psychotherapy (Bohart & Watson, 2020; Kirschenbaum, 2004).

Person-Centered Process

During his many years of professional practice, Rogers noticed commonalities in the process of person-centered therapeutic relationships. These common elements include two persons coming into psychological contact, the client, in a state of incongruence who is vulnerable and anxious, and the clinician who is congruent, meaning real and genuine. The clinician then demonstrates unconditional positive regard for the client and experiences an empathic understanding of the client's internal frame of reference. The clinician then works to communicate this experience to the client (Cain, 2010).

Clinical Goals

Although the specific goals of person-centered therapy depend on the client, there are a few common overarching goals for person-centered work that are broad in nature and include the following:

- To facilitate the client's trust and ability to be in the present moment; this allows the client to be honest in the process without feeling judged by the clinician.
- To promote the client's self-awareness and self-esteem.
- To empower the client to change.
- To encourage congruence in the client's behavior and feelings.
- To help clients gain the ability to manage their lives and become self-actualized (Seligman, 2006).

Qualities of the Clinician

Rogers identified three crucial therapist qualities. *Unconditional positive regard* is the clinician's acceptance of the client for who they are. The clinician provides care, refrains from judging the client, and is a source of complete acceptance and support. This does not mean that the clinician agrees with everything that the client says or does. Rather, the client is seen as doing their best. The clinician expresses concern rather than disagreement. This quality facilitates the change process by demonstrating acceptance. *Genuineness* refers to the therapist's ability to feel comfortable sharing his or her own feelings with the client. This quality contributes to an open therapeutic relationship, demonstrates a model of good communication, and gives permission for the client to be vulnerable in the therapeutic space. *Empathic understanding* is experienced by the client when the therapist acts as a mirror of the client's thoughts and feelings by reflecting them back through the use of tracking and reflective statements. This provides the therapeutic interaction that helps the client increase self-awareness and understanding (Ackerman, 2020; Seligman, 2006).

Link Between Person-centered Approach and Child-Centered Play Therapy

Although Carl Rogers is mostly credited for his work with adults, he began his career, from 1928 through 1940, at the Child Study Department of the Society for the Prevention of Cruelty to Children. During this time, he wrote his book, *The Clinical Treatment of the Problem Child,* one of his first writings related to nondirective techniques intended to be used with children.

Virginia Axline, widely recognized as the originator of nondirective play therapy, was strongly influenced by the work of Carl Rogers. Axline adapted his approach to honor play rather than speech as the child's natural medium of expression (Goicoecha & Fitzpatrick, 2019). In turn, Garry Landreth applied Axline's basic principles of play therapy to his child-centered work in the playroom. Landreth (2012) defined client-centered play therapy (CCPT) as a comprehensive therapeutic system grounded in the belief that children are resilient and have an innate tendency to grow and develop in a self-directed manner. CCPT is developmentally appropriate for children from 3 to 10 years of age, as children communicate best through play (Axline, 1947; Landreth, 2012). In CCPT, the therapist does not direct the therapy or aim to change the child. The therapist avoids imposing the adult's agenda on the child. Instead, the therapist attempts to understand the child and accept the child exactly as he or she is (Goicoecha & Fitzpatrick, 2019).

Child-centered play therapists ground their limit-setting responsibilities in Roger's conditions for personality change. Congruence, unconditional positive regard, and empathic understanding are attitudinal expressions that promote a nonthreatening environment. Limits allow the therapist to maintain psychological contact while setting a limit on the behavior that is not safe in the playroom. At the same time, these limits allow the therapist to acknowledge the child's anxiety or vulnerability (incongruences) and promote the child's perception of empathy and acceptance in the relationship (Ray, 2011). Axline (1947) states that limits in the playroom contribute to a sense of physical and emotional security and she emphasized maintaining empathy and unconditional positive regard when setting these limits.

Cultural Considerations of Child-Centered Play Therapy

Because CCPT is a relationship-based intervention, it is ideal when working with children who have experienced adverse childhood experiences. Post, Phipps, Camp, and Grybush (2019) conducted a review of the literature that examined the impact of CCPT conducted with marginalized children. This review of the meta-analyses revealed that nondirective approaches had larger effect sizes than directive approaches (Bratton, Ray, Rhine, & Jones, 2005) and that non-Caucasian children demonstrated greater benefit from nondirective therapy than Caucasian children (Lin & Bratton, 2015).

Introduction to the Case of Tommy

Tommy is an 8-year-old Caucasian male, short and stocky in stature, who appears physically strong and intellectually advanced for a child of his chronological age. (All names and identifiers have been changed to protect the client's confidentiality.) I began working with Tommy in child-centered play therapy when he was 7 years old. He was referred to the community mental health center for treatment to address his history of sexual abuse, neglect, and loss. Tommy was not only grieving for his biological family and the loss of his powerful role within that family system, but also for his first pre-adoptive family, a placement that abruptly ended after several months. Together with his younger sisters, Tommy had successfully transitioned to his new home and begun to build meaningful relationships there with family, friends, classmates, and his clinician when this placement fell through because of extended family complications unrelated to the children. Tommy's new placement, a significant distance from his previous home, necessitated a change in both his school and community mental health settings. As a result, Tommy experienced more loss, that of his friends, classmates, and the therapeutic connection that he had established with his clinician.

Tommy and his younger sisters were removed from his birth parents' home when he was 6 years old, after significant and ongoing abuse and neglect were substantiated by the child welfare system. Both of Tommy's birth parents had a history of developmental delays and substance use problems. They were unable to meet the care and nurturance needs of the children or provide safety and protection. As a result, from a very early age Tommy assumed a leadership role as a parent and caregiver within his birth family system. Tommy described feeling responsible for not only the care of his younger sisters, but also of his parents. Upon his placement in a second pre-adoptive home, Tommy's need to care for his younger sisters in a parental manner seemed to intensify. Although his new pre-adoptive parents understood the birth family dynamic, they often framed Tommy's parentified behaviors as willful disobedience and therefore responded with a behavioral consequence. The pre-adoptive parents had a long history of providing excellent care for foster children. They successfully completed extensive training about family systems, attachment issues, and the child's need for power and control, but the degree to which they understood Tommy's behavior appeared to be more at an intellectual rather than insightful level. The structure and predictability of the home environment that the parents provided for the children was essential, meaningful and loving and yet it was difficult for them to see Tommy's need to take care of his sisters as a manifestation of the loss of his previous family role, one reminiscent of his birth family, and therefore difficult to relinquish. Although the parents' goal was to help Tommy successfully transition to his new family as quickly as possible, the parent–child interaction was sometimes experienced by the child as minimizing his loss and the depth of his grief. Instead of facilitating growth and healing, it appeared that their somewhat authoritarian parenting style actually exacerbated Tommy's sense of loss and complicated the attachment process.

Other family members living in this new placement included the parents' two biological children, both in high school, an adopted son, also 7 years old, and a foster child infant. Tommy appeared to revere his older siblings, but was most often distant, withdrawn, and irritable with his parents. His relationship with his younger brother was described as competitive, often adversarial, and with significant sibling conflict.

Theoretical Integration

To illustrate the impact of a nondirective stance when working with hurt children and then to compare this approach with more direct interventions, examples from Tommy's therapy sessions are organized here by approach style.

Use of Person-Centered Creative Arts Therapy

Tommy often chose creative expression to reach for insights and work through his loss. Early in his therapy with me (session 4), Tommy used the process of making a necklace to openly discuss his mixed loyalties. As he created the jewelry, he spoke of his birth mother, and how much he missed her and wanted to give her the jewelry. With a confused facial expression, he then said that he would give the necklace to Mary, his adoptive mother, but then later decided to leave the item in the playroom. Reflective statements were used throughout this creative process and were focused on Tommy's ambivalent feelings and reluctance to let go of his hope for reunification. He responded to these reflections with an increase in verbal interaction. He continued with creative options in the playroom by drawing a picture while providing his own verbal narrative. He began by stating that the characters in the drawing were in danger but were hopeful to be rescued. Later, there were elements of playfulness and nurturing in his story, followed by a sense of freedom. Tommy chose to take this artwork home. However, he sealed the art in an envelope and slid it into his coat pocket before leaving the room.

I believe that this art piece and narrative depicted some acknowledgment of Tommy and his sisters' abusive history as well as his understanding and experience that they are all now free from exposure to harm. On the other hand, that Tommy chose to seal his artwork in an envelope and hide it in his coat pocket before leaving the playroom, as well as leaving the necklace behind, indicated a reluctance to share these insights with anyone else at this time. Rather than share these interpretations, which would reflect a psychodynamic approach, I instead mirrored the behaviors and feelings back to Tommy for his consideration, a child-centered response.

Use of Child-Centered Play Therapy (CCPT)

Throughout Tommy's CCPT sessions, he chose a large, rather gruff looking playroom character who represented the judge that made decisions regarding his placement and adoption. Tommy would often verbally express his strong feelings to this character. Although Tommy rarely had the opportunity to talk directly to the judge overseeing his case in real life, he could "talk" to him every week in the playroom, if that is what he needed to do. There were no limits regarding the use of language or decibel level in the playroom. Tommy would yell, "you stole me from somebody" and "my heart is hurt forever" and, in the child-centered playroom, that was all right.

As a prelude to expressing himself through play, Tommy began one particular play therapy (session 10) by summarizing a session with his previous clinician. He described aggressively engaging in intrusive play that appeared to be a powerful therapeutic experience and reflective of past abuse. He looked for my reaction to this graphic description. The content, emotions, and level of intensity were reflected back to him, Rogers' mirroring technique, and Tommy then began to add to his story with an in-depth play narrative in the moment. He used the playroom lighting and a flashlight in a way that projected a large and powerful image of himself against the wall. He then set up a very small space in the corner of the playroom and instructed that I join him there. At this time, my reflections focused on Tommy's need to feel in control, the value of a safe space to tell his story, and on the strength and safety of our therapeutic relationship. In silence, Tommy appeared to be intently thinking for a few seconds and then stated that the space where we sat together is his mother's grave, a place where he can think about her and it is all right. I then mirrored the importance of a safe place to think about and mourn the loss of his birth mother. Tommy nodded his head in agreement and continued to sit in contemplation for a while. He then used the flashlight to focus in on two drawings from one of his earlier sessions that were hanging on the wall across the room. The first, a picture of a broken heart, and the other, a picture of a family, hung side-by-side. He spoke of his birth mother as he began slowly, but then gradually escalating to a rapid pace, moving the flashlight's beam from one picture to the other. He verbalized both his sorrow related to the loss of his mother and some gratefulness for the support of his adoptive family. As he continued to verbally share his complex feelings and mixed loyalties, the beam of the flashlight became a blur between the two images on the wall. Tommy then began to cry aloud that, as he becomes more and more a member of his new family, he is very afraid that he will forget his birth mother. His fears were again mirrored back to him. Through the use of these reflective statements, Tommy experienced validation, felt understood, and this seemed to have a soothing effect. We continued to sit at his "mother's grave" while Tommy shared some good memories of his early childhood, such as going fishing. He shared regretting that he does not know where his fishing pole is right now. I provided active listening and reflective statements about his positive recollections. To include that not knowing where his fishing pole is now might mean that he has no more access to good times

with his birth family would have been an interpretation, again more aligned with a psychodynamic rather than a child-centered approach. Instead, I reflected back Tommy's statement for his own consideration and interpretation.

Tommy then returned to the play narrative and moved to the center of the room. Although not verbalized as such, he seemed to be moving on to another chapter of his story. I used a tracking statement at this point, "now you are moving to the center of your playroom." Tommy continued to use the control of the lighting, but this time it seemed to depict an ominous rather than sorrowful tone. He placed a character often used by children to depict a person in power, a large stuffed "monster," in the center of the room. He then aggressively took out his anger on this "bad guy" while listing losses and sharing pain. He verbalized his grief for the loss of his parents and an uncle who committed suicide, blaming these losses on whomever the playroom character represented. He then continued to punch at the character while he explicitly described an incident of sexual abuse. He expressed feeling like he will "never be able to get over it." Again, rather than interpret the meaning of his play, these powerful images and strong feelings were validated and reflected back to Tommy. As this session ended, he walked from the room, expressing through his posture, body language, and facial expression a sense of feeling understood, in control and empowered. This is an example of a child taking the lead to work through his grief and loss, in the manner of his own choosing, in the safety of his playroom. He did not require an interpretation of his play to move toward healing. He experienced it at his own direction. His resilience and strength were mirrored back to him through tracking and reflective statements. That is all he needed from the therapist.

Direct Techniques

I believe that Tommy engaged best in his therapy when Rogers' nondirective techniques were used. However, as time passed, other approaches were integrated into his care, often to address behavioral reports from the home or school environment. For example, at one point (session 28), some of Glasser's reality therapy concepts were incorporated into our discussion, that of Tommy's unfulfilled needs for power, love, and belonging (Glasser, 1998). Although not confrontational, this was a very direct conversation shared between Tommy and myself. In hindsight, this discussion was clearly too direct, as Tommy's behavioral response was to cover his face and crawl under a chair. His reaction reinforced the value of child-centered interaction. I quickly returned to a nondirective style with the use of tracking statements to describe Tommy's behavior and allowed him the space to verbalize his thoughts and feelings in the moment. He then came out from under the chair, but rather than share his distress through a nondirective play narrative, he maintained a direct approach and verbally described some parent/child interaction that he witnessed in the waiting area that triggered his memory of when he was removed from his parents' home. He described in detail how another family member used force to attempt to "rescue" Tommy and his sisters from the police officer and child welfare worker. Tommy

then framed his family member's behavior as a loving act with the intention of protecting the children rather than aggressive behavior or breaking of the rules. After his feelings were validated, we continued in direct discussion about how this memory influences Tommy's current level of aggressiveness and behavioral choices when he is feeling threatened. This session provides an example of integrating both direct and nondirective responses.

Cultural Considerations of Developmental Stage

Childhood has its own distinct culture. If childhood is a subculture, then the dominant culture is that of adulthood. The child-centered play therapist represents the culture of adulthood to the child and often serves as the translator between these two cultures when interacting with parents (Mullen & Rickli, 2014). I often found this to be the case as I served as Tommy's voice with his adoptive mother. Informed by the vivid narratives Tommy shared in the safe space of the playroom, I was able to offer Mary alternative explanations for Tommy's behavioral choices beyond that of willful disobedience. Linked to his history and framed as working through the grieving process, Mary gradually increased her understanding of Tommy. Likewise, within the nondirective relationship that Tommy and I shared with each other, I could translate Mary's reasonable behavioral expectations to him in a manner that increased his understanding of the value of the healthy family dynamics present in his new home.

Termination

After nearly 2 years of outpatient care, Tommy's parents felt that he had gained as much as he could from the process. Tommy shared a differing perspective, expressing anger over ending another meaningful relationship in his life. We used our last few sessions together to celebrate Tommy's increased ability to better cope with loss. He was involved and receptive to the therapeutic growth that was reflected back to him.

Cultural Considerations

In general, being present in the moment and respecting the client's values, hallmarks of Rogers' person-centered approach, are essential in therapy with culturally diverse clients (Corey, 2009). However, there are shortcomings from a diversity perspective. For example, some clients who seek services at community mental health centers may expect more structure than the person-centered approach

provides. In addition, it may be difficult to translate Rogers' core therapeutic conditions into practice with specific cultures. For some clients, the most culturally sensitive way to express empathy would require a respect for the need for distance (Bohart & Greenberg, 1997). In other cultures that stress the common good, the focus on the development of personal growth may be viewed as selfishness (Cain, 2010). But because the clinician works with the client in an interested, accepting, and open manner, the person-centered philosophy is particularly useful when working with clients who have been marginalized (Bohart & Watson, 2020).

In his essay, *Social Implications,* Rogers shared his vision of applying person-centered approaches to influence larger systems, such as education and medicine. He saw the potential for his methods to facilitate communication between opposing groups involved in political and international conflicts. During the last decade of his life, he facilitated cross-cultural conferences. He saw that acceptance of the whole person in conflicting groups led to "constructive awareness and positive, tension-reducing action" (Kirschenbaum & Land Henderson, 1989. p. 434) and applied his person-centered approach to training policymakers. His efforts were directed toward the reduction of interracial tension (Corey, 2009), and provided a meaningful contribution to exposing white privilege and addressing racial and ethnic disparities in access to resources.

Strengths and Weaknesses

Research findings validate several strengths of the person-centered approach. This therapy offers an optimistic perspective and provides a positive experience when the focus is on clients and their problems. Clients feel that they can express themselves more fully when they are heard by the clinician without judgment and they feel empowered as they are responsible to make decisions for themselves within the therapeutic process (Seligman, 2006). Some weaknesses of this approach include the possibility that clinicians might provide support but without challenging the client to make behavioral change. The clinician's nondirective language may be experienced by the client as passive, weakening the clinical process. In addition, the person-centered approach is not appropriate for those who are not motivated to change and may not be useful when working with clients with significant psychopathology. This approach may also lack the specific techniques that help clients solve their own problems (Corey, 2009; Seligman, 2006).

Discussion Questions

1. What are some ways that a person-centered clinician who is working with children and families can provide parenting support and guidance in a manner that reflects the acceptance of the client as expert?

2. Some clinicians hold that the first priority of therapy for a client who has been sexually abused is to begin by working to resolve the trauma of abuse. In the case of Tommy, the child chose to work through complicated grief prior to processing his feelings related to past abuse. Using your understanding of person-centered concepts, how would you explain Tommy's priorities to the clinician who prioritizes addressing trauma issues?
3. When working with a child, consider how you will respectfully verbalize your informed consent process with the parents that includes your child-centered approach to avoid imposing the adult's agenda on the child's therapeutic process. What will this informed consent sound like?
4. How will you respond to a child who refuses to join you in the playroom with a statement that reflects your unconditional positive regard, acceptance, and respect?
5. How will you maintain a nondirective approach with a caregiver who asks you directly for some guidance and direction with parenting techniques?

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