

Postmodern collaborative and person-centred therapies: what would Carl Rogers say?

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Among the most frequent comments and questions about my postmodern collaborative approach to therapy are ‘It sounds Rogerian’ and ‘Is it any different from Carl Rogers’ client-centred therapy?’ ‘Yes,’ I usually say, ‘there are similarities *and* differences.’ Here I overview the Collaborative and Rogerian approaches, highlight selected similarities and distinct differences, and comment on the relationship of each to family therapy as I see them.

Among the most frequent comments and questions about my postmodern collaborative approach to therapy are ‘It sounds Rogerian’ and ‘Is it any different from Carl Rogers’ client-centred therapy?’ ‘Yes,’ I usually say, ‘there are similarities *and* differences.’ Then I briefly share examples of each; therefore, I appreciate this opportunity to expand my thoughts. In preparation, I revisited a sampling of writings by and about Rogers (Becvar and Becvar, 1997; Kirschenbaum and Henderson, 1989a,b; O’Leary, 1999; Rogers, 1940, 1942, 1951, 1980). I begin with a brief overview of Rogers and his approach and continue with a brief overview of my philosophical preference and a postmodern collaborative approach. These overviews serve as a backdrop for selected similarities and distinct differences, and commentary on the relationship of each to family therapy as I see them. You, the reader, will make your own comparisons, contrasts and conclusions as you read. This article is offered as food for thought and dialogue, not as an academic debate to tear down or integrate.

The Rogerian challenge

Carl Rogers, a pioneering psychotherapist and the most influential

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psychologist in American history (Kirschenbaum and Henderson, 1989b), was a man ahead of his time. Rogers had many firsts. He was the first to offer an alternative to psychiatry and psychoanalysis and the first to record and publish therapy sessions. He was among the first to use personal expression and informal style in his writings. He was also the first to challenge the 'sacred cows' (Rogers, 1980: 235) of mainstream psychology, being particularly critical of research based on logical positivism, traditional modes of education and certification of therapists – challenges he continued until his death. A caveat: In this space I cannot do justice to the philosophy and practices of a man who authored sixteen books and over 200 articles across a nearly fifty-year span. These pages contain only my selection and interpretation of bits and pieces of Rogers' gifts.

Ideas and practices do not spring forth in a vacuum but develop within a context, a history and an era, being influenced by the personalities and passions of their originators. Who Rogers was and was becoming as a person, his personal beliefs about people and human nature, and his interest in a philosophy of life influenced his contributions to psychotherapy.¹ Rogers began his career as a seminary student with a keen interest in philosophy and then moved to focus on the philosophy of education. Early on, working in the child guidance field and later offering psychological services for delinquent and underprivileged children, he found himself always occupied by the same questions: Does it work? Is it effective? And, if yes, or no, why? What he learned as he took this curious and reflective stance, combined with his unique philosophy of life, led him to challenge and move beyond the psychiatric traditions and practices of the time.

Rogers constantly reflected on his professional and personal life experiences, on the client–therapist relationship and on the process of therapy – continually testing and refining his hypothesis or explanatory principle:

All individuals have within themselves the ability to guide their own lives in a manner that is both personally satisfying and socially constructive. In a

¹ Rogers purposefully used the word 'counselling' to make a distinction. In this article I use psychotherapy, therapy and counselling, making no distinctions between their usage. I do not prefer any of these terms; instead I think of myself as a consultant in all of my professional arenas.

particular type of helping relationship, we free the individuals to find their inner wisdom and confidence, and they will make increasingly healthier and more constructive choices.

(Kirschenbaum and Henderson, 1989b: xiv)

All the while, however, he held steadfast to his appreciative belief and trust that human beings have within themselves a 'constructive tendency' (Rogers, 1980: 121) and 'vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior' (Rogers, 1980: 115). In addition, that human beings have 'the tendency to grow, to develop, to realize [their] full potential . . . the constructive directional flow . . . toward a more complex and complete development' (Kirschenbaum and Henderson, 1989b: 137). This belief and trust, in turn, informed the aim of Rogers' approach: to release this directional flow. This explanatory principle became the basis of humanistic psychology.

Rogers' approach focused on the construct of self and on personality change: this was the core from which he developed a theory of personality. The goal of therapy was to move the individual towards maturity, 'as being, *becoming*, or being knowingly and acceptingly that which one most deeply is' (Kirschenbaum and Henderson, 1989b: 62). Accordingly, for Rogers (1940), therapy primarily dealt with organization and functioning of the self and the counsellor served as an alter ego. Therapy was a 'process of exploration of feelings and attitudes [emotional catharsis] related to the problem areas, followed by increased insight and self-understanding' (Rogers, 1940: 133). Fully accepting, recognizing and clarifying feelings, followed by the 'initiation of minute, but highly significant, positive actions' subsequently led to 'increasingly integrated positive action' (Rogers, 1942: 74). Rogers believed that 'if a person is fully accepted, they cannot help but change' (Kirschenbaum and Henderson, 1989b: 61). This process led to positive choices and increased capacity for problem-solving (Kirschenbaum and Henderson, 1989b: 23). The counsellor served as a 'genuine alter ego' (Rogers, 1940: 40) and was like a 'a mid-wife to a new personality' (Rogers, 1951: xi). Although Rogers focused on personality change, he did not place importance on the structure or causes of a client's personality.

Rogers initially believed that three interrelated therapist characteristics were essential to creating a climate that supported and promoted this client-directed competence and growth: genuineness

or congruence, unconditional positive regard, and empathetic understanding (Kirschenbaum and Henderson, 1989a). He later added a fourth characteristic that he called spiritual or transcendental, describing it as the special way a therapist can be spontaneously present with another when the therapist is 'closest to his inner, intuitive self and is in touch with the unknown me . . . then simply my *presence* is releasing and helpful' (Kirschenbaum and Henderson, 1989b: 137). He believed these therapist characteristics or expressions of attitudes and behaviours were a 'way of being', a 'philosophy' (Kirschenbaum and Henderson, 1989a). And, when a therapist lived this philosophy it helped both the client *and* the therapist to 'expand the development of his or her capabilities' (Kirschenbaum and Henderson, 1989a: 138). Rogers thus thought of his approach as a philosophy and his therapist stance as a person-centred way of being. Rogers soon expanded these characteristics to six, presenting them as necessary and sufficient conditions for therapeutic personality change, regardless of methodology (Rogers, 1966).

Rogers referred to his theory as an 'if-then' variety:

If certain conditions exist . . . then a process will occur which includes certain characteristic elements [his six conditions]. If this process . . . occurs, then certain personality and behavioral changes – reorganization of the self-structure with concept of self becoming congruent with experience of the self – toward an unconditional positive self-regard . . . will occur.

(Kirschenbaum and Henderson, 1989a: 240)

From early in his career Rogers was a strong proponent of research, challenging psychological research based on the logical positivism of conventional science as not always appropriate for a human science, believing that such methods risked, for instance, depersonalization and dehumanization, the certainty of knowledge and the myth of objectivity. He called for a more human science of the person that would consider, for instance, human beings as subjective, a person's meanings, and the client as a research partner. Over the years, as Rogers and colleagues researched their own therapy transcripts, they realized that transcript analysis involved mostly paying attention to the details of the therapy content and focusing on the therapist's response. Such analysis risked losing focus of what Rogers thought was the most critical aspect – the client-therapist relationship – and

creating in Rogers' (1980: 139) words, 'appalling consequences'. This analytical position, Rogers (1980) feared, placed the therapist in an expert role and reduced therapy to techniques. Interestingly, little more than a decade ago in *The Carl Rogers Reader* (Kirschenbaum and Henderson, 1989a) Rogers charged that a basic philosophical and methodological question continued to plague the helping professions: 'To what extent do we rely on the individual's ability to guide his own growth and development, and to what extent do we introduce outside motivation, strategies, guidance, direction, or even coercion?' (p. xv). I wonder what has changed, if anything.

Rogers recoiled when colleagues misunderstood his nondirective stance, referring to it as a method or turning it into a technique. On the contrary, the therapist is genuine and spontaneous in her way of being; the therapist 'lives these conditions [characteristics] in the relationship, and becomes a companion to the client in this journey toward the core of self' (Kirschenbaum and Henderson, 1989a: 138). For Rogers, there was no therapy cookbook; the relationship could not be duplicated from one client to the next. Each therapy and each client—therapist relationship was unique.

Reflecting these convictions and in an effort to deal with the misunderstandings, over time Rogers changed the name of his approach from nondirective to client-centred and then to person-centred. Person-centred still reflected an emphasis on the client himself and the client's expertise instead of the problem, but importantly also reflected a new emphasis on the spiritual or transcendental characteristic (Kirschenbaum and Henderson, 1989a). All of the above combined made Rogers, paradoxically, a therapist with enormous popularity and influence whose approach gave a breath of fresh air to the profession. At the same time he became one who was often not taken seriously by his academic colleagues, as some charged that his approach was shallow.

A postmodern collaborative perspective

My journey as a therapist and clinical theoretician has been informed by my various practices and continuous search for concepts to describe and understand experiences of therapy (Anderson, 1997, 2000a; Anderson *et al.*, 1986). Practice and theory go hand-in-hand, each informing the other. Over the years I have

had a sustained interest in client voices.² Like Rogers I have been curious about why therapy did or did not work and why clients found some therapists helpful and others not. Like Rogers I am interested in alternative research methods. My research has been informal – what I think of as research as part of everyday practice and the client as co-researcher – focusing on client voices, reflecting with clients, learning from clients, and using what we learn as we go along with each other in therapy. My constant question, in one form or another, has been, ‘How can therapists create the kinds of conversations and relationships with their clients that allow both parties to access their creativities and develop possibilities where none seemed to exist before?’ (Anderson, 1997).

For twenty years of this journey I learned with my continual *conversational partner*, Harry Goolishian, and simultaneously and subsequently I learned with other conversational partners – my clients, other therapists’ clients, colleagues and students. The search for concepts to help me understand therapy experiences led me down a meandering path and to the place where I have now paused: a postmodern collaborative approach to therapy, education, consultation and research (Anderson, 1997, 2000a; Anderson and Goolishian, 1988).

Philosophical preference

Postmodern, broadly speaking, is an ideological critique of universal or metanarratives, including self-critique. It invites an ongoing sceptical attitude towards the nature and meaning of knowledge, including its certainty and power. Consequently, postmodern offers a broad challenge, and invites us to examine and reimagine our psychotherapy culture and traditions, and the practices that flow from them.

Knowledge and language as relational and generative. Postmodern refers to a family of concepts. Although the family has diverse branches, there is an important trait: the notion of *knowledge and language as relational and generative*. Knowledge (what we know or think we

² In my everyday work I refer to the ‘people’ or ‘person’ I work with; in this article I use ‘client’ for simplification and in the broadest sense, referring to a single person or any combination of related or non-related persons.

might know) is linguistically constructed by people in conversation;³ its development and transformation is a communal process, and the knower and knowledge are interdependent. Knowledge is a by-product of communal relationships rather than an individual possession or product (Gergen, 1994). It is created in and through language, or in and through what Shotter (1993) refers to as 'joint-action'. Knowledge, therefore, is not something static, out there waiting to be discovered; rather it is fluid.

Language (spoken and unspoken communication) gains its meaning through its use, and is the primary vehicle through which we construct and make sense of our world. Words, for instance, do not signify meaning (tell us what something is) but take on their meaning through social interaction and exchange. Language, therefore, is fluid.

Transformation or newness, therefore, is inherent in and emerges within the inventive and creative aspects of language, dialogue and narrative. The potential for transformation is as infinite in variety and expression as the individuals who realize them. This transformative characteristic of knowledge and language invites a view of human beings as resilient; it invites an appreciative approach.

Multiple realities. What is created in and through language (e.g. knowledge, meaning and reality) is multi-authored among a community of persons and relationships. What is created, therefore, is only one of multiple perspectives, narratives or possibilities. There is no one, or, more accurate, reality, truth or privileged representation. That is, the reality or meaning we attribute to the events, experiences and people in our lives is not in the thing itself, but is a socially constructed attribution that is shaped and reshaped in language, in conversation, and in our social practices. For instance, think of the shift in the meaning of family over the past fifty years.

Rogers addressed the notion of reality with conviction and questioned the futility of psychologists' search for the truth: 'The only reality I can possibly know is the world as I perceive and experience

³ I use conversation and dialogue, and dialogical conversation, to refer to inner and outer, spoken and nonspoken, and silent and out-loud thoughts and communication.

it at this moment. The only reality that you can possibly know is the world as *you* perceive and experience it at this moment.’ He emphasized that ‘the only certainty is that those perceived realities are different’ (Rogers, 1980: 96). These are the perceptual maps we live by; the map is never reality itself (Rogers, 1951: 486). Linking perceived reality to change Rogers (1951: 486) said, ‘That the perceptual field is the reality to which the individual reacts is often strikingly illustrated in therapy, where it is frequently evident that when the perception changes, the reaction of the individual changes.’

Beyond the reality differences, Rogers believed that there was ‘a very strong possibility that there is more than one kind of “reality”’ (Kirschenbaum and Henderson, 1989b: 370). There was the possibility of ‘a reality that is not open to our five senses . . . which can be perceived and known only when we are passively receptive, rather than actively bent on knowing’ (Rogers, 1980: 256).

In his later writings, Rogers (1980: 96) asked, ‘Do we need “a” reality?’ Having *a* reality, he came to believe, was a luxury and myth that we could no longer afford (Kirschenbaum and Henderson, 1989b). ‘Reality when it is viewed from the outside,’ said Rogers, ‘has *nothing* to do with the relationship that produces therapy’ (Kirschenbaum and Henderson, 1989a: 51–52). He continued, stressing that what is important, however, is how the therapist responds to the client’s reality. On a global level, Rogers viewed differing realities as a promising resource for humankind to learn from one another without fear – paving the way for change (Kirschenbaum and Henderson, 1989a). I agree with Rogers that differences hold richness and possibility and I have long been more interested in learning about differences rather than trying to negotiate or resolve them (Anderson, 1997). Rogers did not fully address how he thought reality was created. He seemed, however, to view reality as constructed, but as an individual construct similar to a constructivist view rather than as a communal or social construction. This is a difference.

Explanatory principle and therapy goal

My explanatory principle is that human systems are language, meaning-generating systems; the therapy system is one such system in which people generate meaning with each other. Transferring the notion of knowledge and language as relational and generative

to the therapy arena, my approach to therapy and all my practices involves collaborative relationships and dialogical conversations. The therapist aims to invite, create and facilitate this kind of relational and dialogical space and process, giving life to it inside and outside the therapy room. Both client and therapist are at risk of transformation in this kind of space and process. Therapy of this nature, including the client–therapist relationship and the process, becomes more mutual and egalitarian.

My goal is simple: to be helpful to a client with their want, need and agenda regarding their life difficulty. I accept that there is usually more than one reality about the issue, its imagined resolution and my relationship to it, and I accept that I am always working within these multiple realities. I do not presume to have an idea before I begin therapy about what help should look like during or at the completion of therapy. In other words, I do not focus on content, skills, techniques or methods. What might be thought of as such are simply expressions of a philosophical stance, a way of being – utterances and actions – that are unique to and differ from therapist to therapist, from clinical situation to clinical situation, from context to context, and from relationship to relationship.

Philosophical stance

Like Rogers, I think of my approach as a philosophy of therapy rather than a theory or model. Philosophy, for me, concerns itself with ordinary human life: questions about concepts such as self-identity, relationships, mind and knowledge. Philosophy is not about finding scientific truths but involves ongoing analysis, inquiry and reflection. I believe that how I prefer to understand therapy, the client–therapist relationship and transformation and how I prefer to *be* as a therapist reflects a philosophy of life fitting to the professional *and* the personal. Rogers similarly emphasized the importance of congruence in all life roles and relationships such as therapist, teacher and husband. Unlike Rogers who was interested in a philosophy of life in his early studies and practices, I have only come to this idea within the past fifteen years (Anderson, 1997; Anderson and Goolishian, 1988). I am always challenged by my philosophical stance, as a colleague put it: ‘I wonder off and on about the differences between writing and thinking about ideas and living the ideas – living the ideas [the philosophy] is the difficult challenge . . . is indeed a continuous challenge’ (Elmquist, 1999).

My preference for collaborative relationships and dialogical conversations involves a particular kind of attitude or position that I refer to as *a way of being*:⁴ a way of thinking about people, relating with them, talking with them, acting with them and responding with them. I refer to this way of being as a *philosophical stance* (Anderson, 1997).

Intertwined characteristics of a philosophical stance

The characteristics of a therapist assuming this philosophical stance bear some resemblance to Rogers' preferred therapist/therapy characteristics. For instance, the therapist invites, respects and acknowledges the client's expertise; the therapist trusts and believes the client; the therapist is a learner; the therapist is always on the way to understanding; and the therapist is fully present as another human being. Emphasis is placed on the client's expertise regarding his or her life, and the therapist's expertise on how a client should live his or her life is de-emphasized. Said differently, a way of being does not equate skill or technique, contrived or interventive, but natural and authentic.

More specifically, a philosophical stance or a way of being has several intertwined characteristics.

Conversational partners. Client and therapist become conversational partners as they engage in *dialogical conversations* and *collaborative relationships*. Such conversations and relationships go hand-in-hand: the kinds of relationships we have form and inform the kinds of conversations we have and vice versa.

A dialogical conversation is a two-way conversation, a back-and-forth, give-and-take, in-there-together process where people talk *with* rather than *to* each other. Inviting this kind of partnership requires that the client's story take centre stage. It requires that the therapist constantly learn, listening to and trying to understand the client's story from the client's perspective. The therapist is listening to hear what the understanding is for the client, not for the therapist. Listening to hear is active not passive, as the therapist offers

⁴ I did not take the term *way of being* from Rogers nor does it refer to his therapist characteristics. The words simply seemed to best capture a meaning I wanted to convey.

comments, asks questions, and checks out to see if she understands – all part of a dialogical process. That is, questions, comments, or other therapist utterances or gestures are not aimed at a particular direction, answer, newness, etc. The intent is to invite, facilitate and sustain dialogue. In my experience this therapist learning position acts to spontaneously engage the client in a co-learning position, or what I refer to as a mutual or shared enquiry. Such enquiry is an interactive and fluid process in which therapist and client co-explore the familiar and co-develop the new. In this enquiry, the client's story spontaneously clarifies, expands and shifts. What is created (the content) is co-constructed from within the conversation in contrast to the newness being imported from outside it. That is, theory or therapist does not predetermine the newness or the outcome (the content). This is not to say that clients do not have some idea of a goal when they enter therapy, but that the idea, in my experience, often transforms to a lesser or a greater extent within a dialogical process.

A conversational partnership requires that the therapist includes, respects and values multiple voices – appreciating the richness of differences and the possibilities inherent in them. In this kind of conversation and relationship all members have a sense of belonging, and, in my experience, this sense invites participation and shared responsibility. All are part of inviting a collaborative relationship.

Whereas I talk about the therapist as a conversational partner, Rogers talked about himself as a companion. Although similar therapist positions, the intent, the process and the destination of the journey are different. As mentioned above, for Rogers, the therapist accompanied the client on a journey towards the core of self and personality change. As a conversation partner I imagine that I am more active than Rogers was, based on my interpretations of his writings and viewing of his videotapes. For instance, I am more interactively engaged, there is more back and forth with the client as I join with them in a mutual or shared enquiry.

Not-knowing and client as expert. The collaborative therapist, similar to Rogers, considers the client as the expert on his or her life and as the therapist's teacher. A collaborative therapist invites, respects and takes seriously *what* a client has to say and *how* they choose to say it. This includes any and all knowledge whether those descriptions and interpretations are informed by popular cultural discourse, folklore, spirituality, etc., whether they are expressed in a

chronological manner or otherwise, and regardless of the amount of time a client takes to tell the story.

A collaborative therapist does not have a monopoly on the truth, nor superior knowledge. The collaborative therapist, like the client, simply brings her own expertise, not a better one. The therapist tentatively offers her voice, including questions, comments, thoughts and suggestions as simply food for thought and dialogue. *Tentatively* does not refer to being timid or hesitant. It refers to the notion that the therapist's intent is to invite and facilitate collaborative relationships and dialogical conversations, not to impose, directly or indirectly, notions about what a client should be talking about, how they should be talking, or how they should be living.

My view on expertise is related to what I call *not-knowing* (Anderson, 1997; Anderson and Goolishian, 1988, 1992). Not-knowing is a characteristic of the philosophical stance that, in my experience, is critical to inviting, creating and sustaining collaborative relationships and generative dialogues. Not-knowing refers to a therapist's *intent*: how they *position* themselves with what they know or think they know and to a willingness to keep their therapist knowing open to question and change. Not-knowing has been misunderstood as a therapist lacking knowledge, feigning ignorance, withholding knowledge, avoiding suggestions, or forgetting what she knows. It has been misunderstood as an expertise or a technique. Not-knowing is an ethical position: I do not know better than a client how she or he should live their lives; I do not want to use my knowing to lead a client in any direction. I want to promote dialogue in which possibilities can emerge.

Rogers placed emphasis on the client's right to select his own life goals, even though their goals may be at odds with the counsellor's goals for them, and on the client's right to be psychologically independent and maintain psychological integrity (Rogers, 1951). Rogers (1951) early on put forth the notion of therapist expertise as having social and philosophical implications that need careful consideration – seeing diagnosis, for instance, as partly a form of social control and as placing the locus of responsibility for treatment in the hands of the expert. Diagnosis, for Rogers (1951: 220), 'as usually understood is unnecessary for psychotherapy, and may actually be a detriment to the therapeutic process'. Diagnosis, he believed, also risked placing emphasis on problems and problem resolution rather than on the person. Likewise, although from a postmodern/social construction perspective, I have similar strong

opinions about the usefulness and misuse of diagnosis (Gergen *et al.*, 1997).

Rogers also firmly believed that 'The answer to most of our problems lies not in technology [diagnosis and objectifying] but in relationships' (Kirschenbaum and Henderson, 1989b: xvi). 'Taking people apart as objects,' Rogers said, 'is already having a genuine cultural effect which I don't see as healthy' (Kirschenbaum and Henderson, 1989a: 166). Although in his earlier writings Rogers (1951) talked about the techniques of client-centred therapy, he later renounced them, qualifying, interestingly enough, that he believed it was all right to use a technique *if* the technique was to foster one of the six conditions for therapeutic personality change (Kirschenbaum and Henderson, 1989a). As I discussed earlier, this is slightly similar and slightly different in terms of why, how and when a therapist would introduce previous knowing, and that this knowing is open to challenge and transformation.

Continuing along these lines, Rogers believed that offering advice, suggestions and judgements 'only retards therapy' (Kirschenbaum and Henderson, 1989a: 21). From a collaborative perspective, it is not the advice, the suggestion, the judgement or question (for instance, knowing) *per se*. A therapist can say anything, but critical to their expression is intention, manner, timing and tentativeness. It is also important to realize when and how these kinds of therapist ideas or knowing risk building road-blocks, or, to use Rogers' word, *retard* collaborative relationships and dialogical conversations (Anderson, 1987).

Talking about expertise and knowing often brings up questions about power. There are some subtle similarities and differences between collaborative and Rogerian approaches regarding power. Rogers did not seem to focus directly on power, but it was a given for him that the therapy profession was replete with the misuse of power (for instance, diagnosis). Central to his nondirective philosophy and approach, Rogers wanted to locate power in the client (for instance, empower), not the therapist. This was his attempt, accomplished through his way of being, to not misuse power (Rogers, 1980: 140). I believe that therapists have culturally and theoretically deemed power and authority and that these are often, wittingly and unwittingly, misused. I strongly believe, however, that I have a choice about how I position myself with this power and authority. I do not aim to empower a client because I do not believe I can empower another person.

Being public. Therapists often operate from invisible private thoughts – judgements or hypotheses about the client – that can monopolize, influence and guide listening and hearing and utterances and actions. In other words, a therapist's silent dialogue can collapse into a monologue when she becomes fully occupied by one idea about a client, and consequently inhibit therapist and client inner and outer dialogue. Thus, when a therapist finds herself occupied by monopolizing private thoughts, she must do something with these thoughts. There is, however, no one across-the-board what to do and how to do it; this will vary with each client and clinical situation. I often find that making the silent thoughts public or visible is a helpful step towards restoring my inner dialogue, putting it out there as food for thought and dialogue that a client might find interesting, useful or otherwise. I caution, however, that there are forms of sharing which can open dialogue and forms which can close dialogue. It is not a matter of whether there are thoughts or content that a therapist should or should not speak about; rather it is how, when and why they do it.

Rogers did not write about dialogue or monologue but he did stress the importance of the therapist being oneself – being real, open, and aware of and honest about what he was experiencing and feeling. That is, he thought it was important to keep his words and actions in line with his experiences and feelings (Kirschenbaum and Henderson, 1989a). He referred to being oneself as *transparent*: 'The therapist makes himself or herself transparent to the client; the client can see right through what the therapist *is* in the relationship' (Kirschenbaum and Henderson, 1989b: 115). He believed that 'being oneself is being more effective' (Kirschenbaum and Henderson, 1989b: 19). For Rogers, being oneself placed emphasis on the therapist's presence and attitude – a way of being – rather than on skills and techniques.

I prefer 'public' because transparency is often interpreted as a client being able to see through or see the realness of a therapist. It assumes that a client will interpret the realness as the therapist does. A client can only see what a therapist chooses to show, and they perceive, experience and interpret that seeing through what they bring to the encounter.

Although transparency is a concept often used by narrative therapists and its origin is often attributed to feminist therapists, Rogers was the first to introduce it. I am not sure Rogers would have equated transparency and public because I think the intention of

each is different. Further, I do not think Rogers intended for his offering or the manner in which it was presented to promote dialogue as I think of it; rather there was a strategic intent of increased acceptance of his offering: 'I had learned to be more subtle and patient in interpreting a client's behavior to him, attempting to time it in a gentle fashion which would gain acceptance' (1966).

Mutual transformation. I prefer the word *transformation* rather than *change* because from a collaborative perspective the therapist is not an agent of change. That is, a therapist does not change another person. Transformation, for me, helps emphasize a continuous and mutual process rather than one person being changed from-to by another person. Here the therapist's 'expertise' is in creating a space for and facilitating a process for collaborative relationships and dialogical conversations. In this kind of transformative process, both client and therapist are shaped and reshaped – transformed – as they go about their work together.

Rogers talked about mutual client-therapist growth in his person-centred approach as resembling Buber's I-Thou kind of relationship. He believed that therapy was 'a real, experiential meeting of persons, in which each of us is changed . . . in that kind of experience' (Kirschenbaum and Henderson, 1989a: 48) and that 'even as I try to express these feelings, they change' (p. 12).

Uncertainty. When a therapist accompanies a client on a journey and walks alongside them, there is uncertainty. Because the newness (e.g. solutions, resolutions, outcomes) comes from within the local conversation, is mutually created, and is more uniquely tailored to the person involved, there is no way of predicting or knowing for sure where one will end up. Surprises often happen. Rogers (1980) went so far as to say that he was bored by safety and sureness; he was willing to take chances and when he did he learned whether he succeeded or failed. Like Rogers, I find that uncertainty opens doors for learning and it fits with my idea of learning as a lifelong process. And, when you are genuinely curious about another person, walking alongside them, mutually determining the direction and destination, there is no room for boredom.

Everyday ordinary life. Therapy from a postmodern collaborative perspective becomes less hierarchical and less dualistic; it becomes

more like the everyday ordinary relationships and conversations most of us prefer. This does not mean chit-chat, without agenda or friendship. Of course I acknowledge that the therapy relationship and conversation occur within a particular context and with an agenda. Rogers, similarly, said that an implication of his approach was that psychotherapy was not a special kind of relationship, different from others that occur in everyday life (Kirschenbaum and Henderson, 1989b). Rather, the therapeutic relationship was the heightening of his conditions that he believed existed in ordinary relationships.

There are some nuanced differences between a collaborative therapist's and Rogers' way of being – the differences have to do with the intent of a way of being. Rogers deemed his way of being as essential for and aimed at personality development and change that would subsequently lead to a spontaneous and unique resolution of problems. Said differently, the purpose of his way of being was to create a growth-promoting climate. From a collaborative perspective a way of being is related to inviting, creating and sustaining collaborative relationships and dialogical conversations, and the inherent natural, spontaneous and unpredictable transformation. I do not aim for personality development and change for the associated insight or self-acceptance. What change or transformation looks like for Rogers and a collaborative therapist differs.

More similarities and differences

As indicated above, there are similarities between the collaborative and Rogerian approaches. Both have critically challenged present psychotherapy ideologies and traditions. Clinical experiences and curiosities about successful and unsuccessful therapy and therapists influenced both. Both represent the reflective nature of theory and practice. Both approaches share an appreciative and optimistic view of people and their capacity to be experts on their lives, and to resolve their difficulties in ways unique to them and to their circumstances. Both place significant emphasis on the person of the therapist – *a way of being* – and the client–therapist relationship.

Self. Both talk about the *self* from different viewpoints. Rogers referred to a contained core self and the importance of finding and understanding that self. From a collaborative perspective self refers to a socially created *selves* that are relational and unbounded by skin

or mind. Bateson, in a correspondence to Rogers, touched on such a distinction: 'For me, "person" is that "nexus in a floating web of ideas which exist within my skin and outside it." For you [Rogers], I guess that "person" is all contained *within* . . . the world of "person" is non-spatial' (Kirschenbaum and Henderson, 1989b: 401).

Neutrality. Both approaches disregard neutrality but for different reasons. For Rogers, being positive towards a client negated a neutral position. For me, first, it is impossible to be neutral – biases are always present. Second, when a therapist tries to be neutral she is often experienced by a client as having a secret or hidden opinion or agenda. Third, I think in terms of being on a client's side, so to speak, and with multiple persons in a room that would entail being on each person's side simultaneously – multipartiality (Anderson, 1997).

Influences. The collaborative approach has been more strongly influenced over time by ideas outside of psychotherapy that were drawn upon to help make client and therapist clinical experiences sensible. Early post-general, first- and second-order systems theories influences included: evolutionary, nonequilibrium and self-organizing systems, constructivist notions of reality, language as coordinated in behaviour, and philosophies challenging knowledge as representational and singular. Later influences included postmodernism and associated concepts such as social construction, contemporary hermeneutics and narrative theory. All challenge knowledge traditions, and consequently, how human systems are conceptualized.

Rogers called for new models of science that were more appropriate for human beings (Kirschenbaum and Henderson, 1989b). Later in his career he was inspired by and found support for his hypothesis outside the psychotherapy literature, as we similarly did but not for the same reasons: Polany's philosophy of science, Maruyama's theory of mutual cause-effect, Prigogene's theoretical physics regarding systems and complexity, the new enquiry methods of researchers like Reason, Rowan, Polkinghorne and Patton, and the contemporary hermeneutic methods of interpretations (Kirschenbaum and Henderson, 1989b). What these perspectives had in common for Rogers, as well as for my colleagues and myself, was a challenge and alternative to our knowledge traditions. Rogers did not talk about postmodern or social construction ideas *per se*.

He died in 1987 just as the social sciences were gaining interest in these perspectives and when my colleagues and I were deep into their exploration and application. My guess is that if he were alive today his passion for alternatives to traditional scientific inquiry would have led him in a similar direction.

Even though there are similarities between the two approaches in the arena of client–therapist relationship and an appreciate view of humans, *there is a significant difference in therapist intention, goal of therapy and the process of therapy*. Rogers developed a theory of personality, personality development and personality change that informed his theory of therapy and its person-centred framework. Personality development and change were his therapy goal. The relational context and change process towards this goal were created in Rogers' six conditions.

The collaborative approach aims to invite, create and facilitate a generative process, achieved through collaborative relationships and dialogical conversations. Transformation is inherent in this process; no importance is placed on the direction, content or product of this transformation.

Educating therapists

The Collaborative and the Rogerian approaches both discuss the implications that each has for arenas of human behaviour beyond the therapy room. Rogers (Kirschenbaum and Henderson, 1989a) was especially concerned with, and his work later addressed, the broader social implications of a person-centred approach, believing it had the potential for dealing with major social issues. His commitment and passion for a more human world was acknowledged by a nomination for the Nobel Peace Prize.

Both approaches place major emphasis on learner-directed learning. Rogers had a lifelong dedication to education and particularly the education of therapists. 'Can we influence a profession?' Rogers asked (Kirschenbaum and Henderson, 1989b: 330). If influence is at all possible, Rogers suggested that the avenue was through the training institutions, beginning by providing a more person-centred experience for educators who train professionals, and who in turn can create person-centred modes of learning.⁵ He strongly

⁵ Interestingly, Rogers before his death said that no psychology programme in a major academic institution taught a person-centred or humanistic psychology. I

believed, however, that a precondition was imperative: 'a leader or a person who is perceived as an authority figure in the situation is sufficiently secure within herself and in her relationship to others that she experiences an essential trust in the capacity of others to think for themselves, to learn for themselves' (Kirschenbaum and Henderson, 1989b: 327).

Most of the characteristics of Rogers' view of person-centred learning – self-initiated learning, meaningful and experiential learning – resemble what others and I refer to as collaborative learning (Anderson, 1998, 2000c; Anderson and Swim, 1993; Brufee, 1999; Peters and Armstrong, 1998). Collaborative learning places the learner in charge of the learning, including the development of curriculum and evaluation. It moves beyond the individual learner, emphasizing students learning *with* each other and within collaborative learning communities. The role of the teacher from collaborative and Rogerian perspectives is facilitative or a leader who leads by following. I agree with Rogers when he said, '*My experience has been that I cannot teach another person how to teach [Rogers' italics]*' (Kirschenbaum and Henderson, 1989a: 301). Harry Goolishian and I often said, and I still believe, that we could not teach a person how to be a therapist but we could provide an experience in which they could *learn* to be one (Anderson, 1997, 1998, 2000c).

Where is the family?

The collaborative approach represents a philosophy and the practices that flow from it – a way of conceptualizing human systems and their life dilemmas and the role of the therapist. The approach represents a major challenge to the traditions of family and individual therapy and the distinctions between them. It is a paradigmatic shift that does not dichotomize or privilege individual over social and does not view individual and family as competing constructs. It therefore does not distinguish between target-of-treatment social systems, for instance, individuals, couples or families (Anderson, 1997; Anderson and Goolishian, 1998; Anderson *et al.*, 1986; Goolishian and Kivell, 1981). Either distinction limits. The focus of the approach is the person(s)-*in*-relationship.

an evidence of this. Rogers was never mentioned in my undergraduate or masters programme, nor for some unknown reason was I curious about his work in my doctoral programme. I was given *Client-Centered Therapy* by a supervisor in the late 1960s.

The preferred philosophical stance and the associated collaborative relationships and dialogical conversations can take place regardless of the number of persons in a room. A collaborative therapist assumes the same philosophical stance with one or multiple persons in a therapy room. This same stance is assumed with students in a classroom, participants at a workshop, participants in research and members of organizations.

On the other hand, Rogers' life work focused on the individual. He did not work with or write about couples and families. From my interpretation of his words, he believed that it would be difficult to be present, have the needed focus, and achieve the kind of relationship and subsequent personality change he strived for if there were multiple people in the room. In addition, he took the position that the changes made by the client, for instance, their more realistic and accurate perceptions, their acceptance of others and the associated behavioural changes, would have positive influences on their family or other significant relational systems.

Finally . . . has 'family therapy' ignored Rogers?

I have heard some family therapists charge that family therapy has ignored Rogers. In my opinion, family therapy has not ignored his contributions as much as it may have taken him for granted. I think that his contributions regarding the person of the therapist and his preferred client–therapist relationship have become so embedded in our psychotherapy culture that they have become givens. That is, how most therapists *aspire to be* is similar to Rogers' therapist characteristics. I think it is difficult, however, for family therapists and therapists of other persuasions to *be* fully Rogerian, so to speak. The notions of therapist expertise and techniques, including knowing the pragmatic results ahead of time, are so deep-seated in our psychotherapy culture that basic relational characteristics like those that Rogers put forth get lost. Said differently, beliefs, values, theory and professional context are not always compatible and often compete. Exceptions as I see them are the fringe approaches like collaborative and narrative oriented – for instance, the works of Tom Andersen, Harlene Anderson, Lynn Hoffman, Jaakko Seikkula and Michael White, and their extensions by others – therapists who are not bounded by the notions of individual or family and all place emphasis on the client–therapist relationship.

I do not think that it is a matter of translating Rogers' individual

approach to working with families, but an ethical matter of seriously evaluating and reflecting on the beliefs, values and theories we hold about human beings and human relationships – how do we want to *be* with others, how do we conceptualize others, and how do we conceptualize our task? I wonder what Rogers would say?

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