CHAPTER 6

AUTHENTICITY AND ALIENATION: TOWARDS AN UNDERSTANDING OF THE PERSON BEYOND THE CATEGORIES OF ORDER AND DISORDER[1]

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Don't ask the doctor, ask the patient
Jewish proverb

If we take the Person-Centered Approach (PCA) seriously as a *client*-centered approach, we have to go back to our clients in order to engage them in an individualized, shared process of encounter and reflection. Following Rogers it is argued that the essential conditions of psychotherapy exist in a single configuration, even though they occur uniquely with each client. From a dialogical point of view, therapists and clients are not only seen as being *in* relationships; as persons they *are* relationships, which makes them different in each therapeutic contact. Furthermore, the traditional concepts of psychological health and disorder are rejected, seeing symptoms as a specific cry for help that has to be understood in a process of a personal encounter between therapist and client. Following this concept it is appropriate to speak about clients as persons who are suffering from inauthentic or alienated forms of being in the world. The value of concepts and conceptions for helping us understand different types of clients are acknowledged and emphasized. However, the existing concepts for, and descriptions of, our clients still exist only at a primitive, unsystematic stage of development and thus we need the development of a genuinely human science of Person-Centered Therapy.

PERSONAL ANTHROPOLOGY: AUTHENTICITY AND ALIENATION

Carl Rogers' approach to mental health was humanistic, not medical. Taking the point of view of the social sciences, not the natural sciences, his holistic standpoint on human beings encompassed not only the biological and individual nature but also the relational and social nature of the person. From the very outset, Rogers' psychology was a social psychology (Schmid, 1994, 1996). In trying to understand the human being within his

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or her respective frame of reference Rogers came to view every individual as a unique being. Therefore, as opposed to an observational and analytical approach, he stood in the tradition of phenomenology, existentialism, hermeneutics and constructivism (Zurhorst, 1993).

THE SUBSTANTIAL-RELATIONAL NOTION OF THE PERSON AS A SOCIAL CRITICISM

But Rogers' personality theory is not only a social psychological theory; it is also implicitly social criticism, a critical theory of socialization. Central to his understanding of the person is the process of authenticity, the perpetually striven for congruence between the 'experiencing organism' and the self concept. For a long time this was misunderstood individualistically, as referring only to isolated individuals. On the contrary, Rogers (1965: 20) clearly stated that the nature of the human being itself is 'incurably social'. From a personal, dialogical viewpoint we are not only *in* relationships; as persons we *are* relationships. Therefore the human person must be understood at one and the same time from both an individual or substantial view (which points to autonomy and sovereignty) *and* from a relational view (highlighting interconnectedness and solidarity) (Schmid 2001, 2002a, 2003). Self-determination *and* interrelatedness refer essentially to one and the same human nature; we only view and experience these as different dimensions. To regard the human as a substantial-relational being is what is meant by designating him/her as a person. Therefore any *person*-centered consideration on what 'healthy' or 'fully functioning' means, must include a theory of social criticism.

'PSYCHOLOGICAL HEALTH': A THEORY OF AUTHENTICITY INSTEAD OF A 'HEALTH' CONCEPT

Authenticity as the process of balancing individuality and interrelatedness

To be a person means to be truly called living the process of authenticity, developing one's potential in a constructive way. To live authentically means to be able to keep the balance, or better, to gain always anew the synthesis between the substantial and the relational task of living. A man or woman is authentic if they maintain this balance in the process of realizing their own values and needs, their individuality and uniqueness, while *at the same time* living together with their others and the world, meeting the needs and challenges of these relationships in interdependence and solidarity. Who is fully him-/herself is fully social, and vice versa. Self-realization and solidarity coincide. This is how Rogers viewed what he called the 'fully functioning person'. It was not by coincidence that Rogers referred to the biblical notion of 'agape', which embraces both dimensions: 'You shall love your neighbor as yourself.' (Leviticus 19:18; Matthew 22: 39)

From a superficial point of view, a person who lives this process of authenticity is called 'healthy' (etymologically connected with 'whole'), 'sane' or even 'normal' or 'in order'—whence the term 'dis-order' derives. This is in line with the meaning of 'in-

firmity' or 'dis-ease'. But authenticity has nothing to do with being firm or at ease. These common terms are not only misleading, but completely wrong (see Sanders 2005, Chapter 3 this volume), because a severely ill person can live very authentically. This includes pain, fear, grief, struggle, sorrow, agony, transience, and stages of inauthenticity in which there is a new striving towards balance. It also means that each person is different in their way of being authentic.

Rogers always thought about the fully functioning person in terms of the *process* of becoming, never about a state or an end product. The significant meaning of authenticity is to live to become more and more authentic, that is, to become the author of one's own life (Schmid, 2001).

In summary: The image of the human being in person-centered anthropology differs qualitatively from the respective image in the natural sciences. It is human science, not natural science. Thus person-centered thinking sets out from a process theory of authenticity, not from a theory of failure or disorder. The person is understood as an existential process, a process of striving towards authenticity in every given moment of his/her existence, a joint process of self-development and relationship development. Therefore person-centered in itself is process-centered (which is clearly different from process-directive). In the view of a genuinely personal anthropology it makes no sense to separate the process from the person and it is impossible to separate content and process: in a very significant sense the process is the content is the meaning. (Therefore it also seems to be artificial to separate between relationship-, content- and process-experts.)

ALIENATION: THE SUFFERING PERSON INSTEAD OF A CONCEPT OF 'DIS-ORDERS'

Trouble with the ongoing process of becoming authentic can be caused by the development of an inauthentic self-concept or by the lack of the development of some parts of the organismic experiencing capabilities (Spielhofer, 2003). In both cases, inauthentic or missing relationships play a crucial role, because a person becomes, and is, the relationship they have, as stated above. A person becomes inauthentic, if they are alienated from self and Others, i.e., from the experiencing organism and the necessary genuine relationships. Psychological suffering is usually the result. Such a process must be understood as a fundamental self-contradictoriness (*Selbstwidersprochenheit*; Zurhorst, 1993) between the capabilities and the natural process of experiencing, on the one hand, and the rigid and in itself torn structure of the self and resulting rigid relationships, on the other hand.

Inauthenticity and maladjustment

Consequently, for a critical theory of socialization, diagnosing and repairing a deviation from a norm is not an appropriate guideline. In trying to understand how far a person is alienated from self, the prevailing and ruling cultural norm cannot be a constant, although it must be taken into account. This notion of 'inauthenticity' differs qualitatively from the common meaning of illness or disorder. What is experienced from an internal

frame of reference as 'psychological suffering', from an external point of view is seen as alienation or maladjustment. If it is called 'disorder', one must *permanently* keep in mind that the 'order' always is also a cultural norm.

The 'deviation' can appear to be more on the substantial side, inasmuch as there are problems with a person's individuality and being all wrapped up in the social roles, e.g., what is called melancholy, or it can look as if the difficulties are more relational, when a person refuses to engage in their social tasks, e.g., with schizophrenia (see Zurhorst, 1993). No matter whether it is a deficit of substantial authenticity in the sense of 'not being who you are' or a deficit of relational authenticity in the sense of maladjustment, in either case the *person* is suffering. The 'maladjusted person' (see Rogers, 1959)—a term matching with the 'fully functioning person'—who has not succeeded in gaining the authentic balance always suffers from both sides: they lack self-confidence due to an incongruence between self and experience (autonomy deficit) *and* lack trust in the world and others due to an incongruence between the others as perceived by the self and the others as really being Others (relationship deficit). So, suffering due to alienation is a signal of a deficiency or a loss of authenticity. A psychological symptom therefore is a cry for help. (Schmid, 1992)

The symptom as a specific call for help to overcome inauthenticity

The Greek word 'symptom' originally meant 'coincidence, temporary peculiarity'; only later came to mean 'sign, warning, distinguishing mark'; and finally took on the medical sense of a 'characteristic sign of a specific disease'. A symptom is a phenomenon, something that is shown by the person. As everyone familiar with the psychiatric field knows, symptoms often appear to be accidental, they can be subject to fashion; e.g., think of co-morbidity and the intercorrelation of symptoms. One and the same client is quite often given a variety of diagnoses, frequently even contradictory ones.

In the light of a philosophy of the person, a symptom is always a specific cry, coming out of the attempt to be seen and receive help. It is an expression of being severely out of balance in the process of striving for authenticity and the request for support, an attempt to deal with a situation by notifying oneself and others of the balance problem. In the specific cry lies the key to the understanding of the suffering person. It might often be a compromise between the problem and the request for help, but in any case it is, on psychological, mental, physical levels, a *unique* expression of this particular person in this particular situation, an expression of the wish to be understood and to understand oneself. It is a call to others, to overcome the vicious circle and to get the process of authentic personalization restarted. Thus it always creates a unique situation of relationship. In this the key for therapy is to be found.

Symptoms are as manifold as persons and situations are manifold. Many authors who regard differential treatment as necessary, reproach the Person-Centered Approach for adhering to a uniformity myth. What a gross misunderstanding! According to personal anthropology, each suffering person is not viewed uniformly but is seen as entirely different. And so the therapeutic answer is: not uniform but unique (Schmid, 1992).

In summary: Inauthentic persons are alienated from themselves and others. Suffering persons are communicating to themselves and others by symptoms that their process of striving towards authenticity in a given moment of their existence has severely failed or got stuck, that they need help in their processes of self and relationship development. Since the person is *their existential process, the task is to understand the particular process, which is the same as understanding the particular person. The challenge is not so much what has gone wrong, but where the possibilities are to facilitate the process of life, i.e., the self-healing capacities.*

THERAPY: PERSONALITY DEVELOPMENT THROUGH ENCOUNTER

If it is correct that the reason for alienation and suffering is inauthenticity and therefore relationship, then it is also relationship that helps. Aptly, the kind of relationship that can reconcile the alienated person with self and the world was called 'encounter' by Rogers (1962).

Person-Centered Therapy is such a relationship: the facilitation of personalization (i.e., becoming a person) as a process of becoming independent and of co-creating relationships. Thus, therapy overcomes the stagnation (Pfeiffer, 1993). From a relational point of view, therapy is personal encounter; while from a substantial point of view it is personality development (which, by the way, sets the person-centered stance clearly apart from a merely systemic view as well as from other ahistoric therapies). That is, personalization occurs through encounter, personality development by working at relational depth (Mearns, 1996).

Thus, although symptoms are manifold, the answer is always of the same kind: a certain relationship. Despite symptom specificity, the answer is a special kind of relationship. The same relational conditions that are crucial for the development of the infant and child are necessary and sufficient for psychotherapy. Psychotherapy is a special chapter of developmental psychology.

Therefore the relationship is always the same and always different: the same, because it is always the presence (unfolded as the core conditions; Schmid, 2002b, 2003; Geller, Schmid and Wyatt, 2003) of the therapist that is needed and constitutes the answer to the cry expressed by symptoms. It is unique, because it is the special relationship of the persons involved at any given moment of the process that is needed, co-created in the encounter process.

Does this mean 'intervention homogeneity' (Heinerth, 2002)? Yes and no. Yes, because therapy is independent of symptoms and circumstances, insofar as it is always the same 'type' of relationship that is needed: encounter. No, it is specific because two or more unique persons are involved in unique moments of encounter. Differentiated answers are necessary according to differential cries and different perspectives that the client expresses. They require differential empathy for the moment-by-moment process of the client's self-exploration and the forms of relationships that are offered.

In summary: Person-specific is not symptom-specific, or problem-specific (Mearns, 2003), or disorder-specific, and not at all disorder-oriented, but instead is uniquely process-specific.

Consequently, disorder-oriented or goal-oriented is not person-oriented or process-oriented. Since it is the relationship that facilitates the process of personalization, differentiated relationships are needed: each person-to-person relationship is different, otherwise it would not be a personal *relationship. But the kind of relationship is always the same: an encounter, although in very different ways. The client is seen as an active self healer 'using' the therapist for support in this 'co-created interpersonal process' (Bohart, 2003). As a part of the relationship, the therapist is different, if the client is different.*

PHENOMENOLOGICAL EPISTEMOLOGY: ACKNOWLEDGEMENT AND KNOWLEDGE

If we were fully functioning persons we could always, with all persons and moment by moment, be the person the client needs in the given moment and provide the answers the client needs, thus creating the optimal relationship at any given instant. But we are not fully functioning persons, we are all more or less maladjusted persons. This raises the question, What we do 'have' that can be of help and that can allow us to enter encounter processes in difficult relationships, in spite of our being restricted by our own fears and security needs?

The answer is: we have our ability to reflect. We have our intellect.

THE RELEVANCE OF KNOWLEDGE AND CONCEPTIONS IN PCT

Acknowledgment: the art of not-knowing

In immediately encountering another person I do not think about what I could know about him/her; rather I am ready to accept what they are going to disclose. This is a change of epistemological paradigms of tremendous importance for psychotherapy. It expresses acknowledgement as an active and proactive way of deliberately saying yes to the Other as a person. Specifically, this portrays psychotherapy as the art of not-knowing (Schmid, 2002a), the art of being curious, open to being surprised—a kind of sophisticated naïvety towards the client, where the challenging part is the unknown (see Takens, 2001) and not-yet-understood, the openness to wonderment, surprise and what the client has to disclose. 'Each experience, which deserves this name, thwarts an expectation' (Gadamer, 1999: 362). Thus back to the client! For a new, truly human image of the human being we need what Mearns (2003) calls a new epistemology.

Reflection: the human capability of dealing with experience

But life is not only surprise. We are able to think about our experiences and create expectations. We form specific concepts and theories. We inevitably do so and should be aware of this instead of ignoring it: we cheat ourselves if we think we do not think, expect and categorize. For a personal encounter relationship, both are necessary: acknowledgement *and* knowledge; experience *and* reflection.

Experiences lead to reflection. In order to be a personal encounter, therapy needs reflection both within and outside the therapeutic relationship. Reflection is necessary for a personal relationship not only *after* or *outside* therapy (e.g., in supervision, theory building or scientific work), reflection is also needed *within* the relationship, together with the client. A therapeutic encounter relationship is not only co-experiencing; it also is 'co-thinking' (Bohart, 2003). First, there is the immediate presence of persons, and then there is the co-reflection by the involved persons about the meaning of their encounter experience. The experience needs a second view, a critical view from 'outside' of the immediate encounter but within the relationship. The experience needs to be looked at, thus objectifying it. Only after this does the 'initial encounter' become a 'personal encounter' relationship.

As encounter philosophy has discerned, all en-*counter* processes start by being affected by the essence of the Other, of the unexpected as something or somebody that I experience as *counter* to me. Encounter means to face the other person, thus appreciating them as somebody independent, as an autonomous individual, different from me, and worthy of being dealt with (Schmid, 1994, 1998, 2002a). What at first is always an 'initial encounter', a naïve encounter as experienced by an unaffected child, becomes a 'personal encounter' by the passage through reflection. It needs the potential to make oneself, Others and relationships into objects of reflected awareness, thus overcoming the mere naïvety and unity which lie before freedom and responsibility. Distance is necessary for reflection. In this way, analyzing and evaluating become feasible, and with them so do the freedom and responsibility that characterize a mature encounter relationship. This free and responsible way of relating is the pre-condition for understanding what the call of the Other means and for the ability to answer adequately.

Immediate encounter and reflection modes

In the *process of immediate encounter* the epistemological road goes from client to therapist, so that the therapist asks, 'What does this person show, reveal, indicate?' (Not: 'What do I see over there?') Or: 'What can we understand, comprehend, empathize?' The movement goes from the Thou to the I, constituting a Thou-I-relationship (Schmid, 2002a). In this way we need to go 'back to the client' as our starting point, to a truly *client*-centered approach.

In the *process of reflecting*, however, the epistemological movement is the opposite, and so we ask, 'What do we perceive?' This requires that we look at the experiences and reflect on them (though sometimes or initially it might be only the therapist who starts reflecting).

Both epistemological movements are necessary; we need the subjective and the objective. In good moments of therapy they alternate, often quickly oscillating between both modes. The more reflecting follows experiencing and is connected with it, the more it feels like a holistic process, as 'one whole step'. (If the order is reversed or if encounter is missing at all, it is no longer *person*-centered therapy. If the critical reflection is missing, the therapist would no longer be the counter-part in the en-counter.)

In the '*immediate encounter mode*' it is impossible to do anything different from experiencing (otherwise one quits the encounter mode). Categorization is impossible: clients do not show categories, they show themselves (or parts of them)—even if they use categories to describe themselves. Rogers (1962:186–7) was very clear on this

> ... the existential encounter is important ... in the immediate moment of the therapeutic relationship, consciousness of theory has no helpful place ... we become spectators, not players—and it is as players that we are effective ... at some other time we may find it rewarding to develop theories. In the moment of relationship, such theory is irrelevant or detrimental ... theory should be tentatively, lightly, flexibly, in a way which is freely open to change, and should be laid aside in the moment of encounter itself.

While in the encounter mode categorization is impossible, in the '*reflection mode*', the—whenever possible shared—enterprise is to understand the meaning of what was just experienced, and so we must use categories. We may feel reminded of an earlier situation with this person or of somebody similar, or an experience we have had ourselves that we use as comparison. We recognize that a feeling was stirred up that we had in another situation: although it was somewhat different, it feels similar. And so we create and use categories, concepts and conceptions. We cannot not think. We cannot not categorize: we cannot (and shouldn't) ignore that a certain behavior reminds us, let's say, of puberty. If we use this concept after the respective encounter experience, it can help us to better understand what the client wants to have understood and how they stage and direct the relationship. Categories and concepts may not be systematically reflected upon or hardly reflected on at all, but they always rule our acting.

Conceptions and categories

It is important, however, not to think that the self-created categories are given by nature. We need to be aware that the concepts and conceptions are our own constructs. We have to avoid reifying or ontologizing the categories created by ourselves. In the immediate encounter mode we experience, while in the reflection mode we perceive, which means 'to take'. But if we think that we just take what is there, we are wrong. We are construing what we think we see. We cannot perceive without pre-*inform*-ation. We do not look at the client with eyes that have never seen a client before. We are ourselves no *tabulae rasae*, but are biased by our experiences and the concepts derived from them.

Therefore we must be aware that *we* are the ones who determine what we hear and see, and how we arrange what clients tell and show. We decide about the frame of reference of our perceptions out of a pre-understanding and pre-interpretation (Spielhofer, 2003). Thus we need to be aware that a person does not 'have' a disorder, she 'is' not 'out of order' (Fehringer, 2003). A phenomenological approach rather requires the question: In which situation does he/she *show* something? On the basis of personal anthropology it is not possible to say what a symptom or a cluster of symptoms means, i.e., what the client wants to say, merely from an external frame of reference—without taking the relationship and thus ourselves and the cultural context into consideration.

Though it is impossible to think without concepts, we must keep in mind that they are likely to be more wrong than right (e.g., they always oversimplify). Therefore clients must have a chance to upset our concepts. To do this, we need first of all to disclose our concepts and to keep them as transparent as possible. Implicit conceptions must become explicit in order to be falsifiable. Clients must have a chance (even more: must feel invited) to falsify the therapists' concepts and conceptions. These need not only to be open for correction, they must invite correction. They must be ready to be upset and exploded. The last word for the therapist always has to be the Socratric 'I know that I know nothing'.

Existential knowledge: Context-, experience- and relationship-based

We have the choice either to use randomly what pops up in our mind, coincidental intuition or whatever, biased by ourselves, or we can reflect on the conceptions we have and investigate them in a scientific way systematically, that is, methodically and in dialogue with others, which will reduce the probability of systematic errors or biases. Responsibility requires reflecting on our conceptions.

This means: in the reflection mode we work with knowledge. From a personal point of view, this needs to be existential knowledge—knowledge that can provide a basis for our decisions to act. It must come out of experience and must remain bound to it and open to be changed by it. Reflected conceptions have to be process conceeptions, which do not pin down but open up. Such knowledge means to be in-form-ed, to be brought 'in form' by experience and reflection on experience. Experience-based knowledge does not ask whether something is *absolutely* (i.e., detached from the context) right or wrong, it can only be 'right' or 'wrong' within the *relation*-ship. Relevant knowledge is not only relationship-based, it is necessarily context-based and dependent on culture and social norms. (Just think how many people were instantly 'cured' when homosexuality was removed from the list of diseases; now 'Gay and Lesbian Issues' is a division of APA! (Fehringer, 2003).)

So, for knowledge the same applies as for empathy: back to the client! Clients are the ones who in-form us about the next steps in therapy. They bring us 'in form'. Knowledge serves understanding, empathy and acknowledging (i.e. unconditional positive regard; see Schmid 2002a). Empathy is always knowledge-based. Existential knowledge 'in-forms' empathy, 'in-forms' understanding, and thus can be of help, just as theory 'in-forms' practice (Iossifides, 2001). Knowledge fosters therapeutic understanding: Ute Binder (1994: 17–18) is convinced that, at least in the clinical field, we stay far below the possible and necessary level of the realization of the core conditions if we do not try to understand specific phenomena, the respective ways in which they are experienced and the conditions under which they develop. Binder and Binder (1991) emphasize that empathy needs knowledge about disorder-based specific peculiarities, or at least is furthered very much by it. This does not mean that the therapeutic conditions are not sufficient and need supplementation or addition by knowledge; rather it means that knowledge is an intrinsic part of the realization of the conditions. (Only barely enlightened, allegedly person-centered people play knowledge off against relationship and emotion.)

In summary: Epistemologically, the person-centered process of understanding is a process of personal encounter. This includes the process of experiencing, acknowledging the Other and empathy and *the process of reflecting on the co-experiences. Both modes require each other. The task is to personally and professionally handle the resulting dichotomy of not-knowing and knowing, acknowledgement and knowledge. To be truly a personal encounter there needs to be reflection within and outside of therapy. Reflection is based upon knowledge and leads to new knowledge. Although knowledge must not get in the way of the immediacy of encounter, it must be seen as an essential dimension of a personal encounter relationship. A personal use of concepts, conceptions and theories does not hinder experience but fosters it.*

DO WE NEED DISORDER-SPECIFIC CONCEPTIONS AND DIAGNOSTICS?

Therefore the crucial question or decision is which theories we use. On which conceptions do we base our therapeutic endeavor? Which knowledge do we choose to determine what we do? On the basis of a personal understanding, presence and reflection belong to each other and require each other as stated above. We need to offer the client the best conceptions available, the best to foster presence and personalization. The phrase 'to the best of one's knowledge and belief' shows clearly that this is an ethical task, just as doing psychotherapy itself is an ethical enterprise (Schmid, 2002a, c).

Disorder-specific?

Since we need reflection, concepts and knowledge to help us understand the processes in and with our clients and in ourselves as well as possible, it becomes clear that it is useful and necessary to have knowledge about specific processes in the person (which is different from the misleading term 'disorder'-specific knowledge). Rogers himself acted differently in different situations; he further developed his way of doing therapy and modified it (e.g., after the Wisconsin project and encounter groups experiences), even though he did not systematize and classify this. He clearly stated, 'with some fear and trembling', because of a 'heavy weight of clinical opinion to the contrary' that 'the essential conditions of psychotherapy exist in a single configuration, *even though the client or patient may use them very differently*' (1957: 101; italics mine). The second clause of the sentence is often overlooked, though it is essential and marks the task: to understand how clients use the relationship differently. Again: back to the client! Different ways of relating by the client in-form the therapist to relate and respond differently. This is crucial, because the relationship is unique. Each client deserves to get the answer and the relationship they need, and—this seems self-evident from the relationship conditions—not some preset 'type of intervention'.

At the same, we need concepts that help us to reflect on our therapeutic experiences, because it is better to act on the basis of critically reflected knowledge and scientifically investigated conceptions than on coincidental and randomly acquired knowledge. Thus it is essential to develop carefully grounded and considered, genuinely developed systems of concepts. In this sense, process-differentiation makes sense, as do specific concepts when they help us to better understand different authentic and inauthentic processes.

On the other hand, *disorder*-centered conceptions are not *person*-centered (see Mearns (2003): 'Person-centered is not problem-centered').

Quite a lot of person-centered 'disorder'-specific knowledge exists. There have been many attempts to describe and better understand characteristic processes. In recent years many theoreticians and researchers have made much effort, and there is quite a body of literature. Out of different motivations—to be recognized by the authorities, to communicate with colleagues, to further develop understandings of PCT—numerous conceptions were developed. The experiential movement deserves credit for strongly emphasizing the necessity of conceptions. The work of Hans Swildens (1988), Ute and Johannes Binder (1994), Margaret Warner (1998) and Garry Prouty (Prouty, Van Werde and Pörtner, 2002), for example, have contributed substantially to our understanding of person-centered processes and to the development of PCT theory.

Furthermore, much time has been spent on finding a way of dealing with the prevailing conceptions of medicine and psychiatry, the other therapeutic orientations, and the requirements of the public health system. It seems clear that simply to adopt one of these other systems of thought will hardly correspond with person-centeredness. As a result quite a few attempts have been made to translate traditional models into person-centered categories. Although we cannot ignore these traditional conceptions and therefore must understand them, and although we are often forced to use them in order to communicate with colleagues and institutions or simply in order to get access to social security money, I am convinced that they are not at all consistent with the image of the human being as a person. (In the same way, in training lack of self-assurance and competence should not be replaced by rules and techniques; instead, training should support personalization and further trust in one's own capabilities and a proper reflection on them just as therapy does.)

It is now my turn to state 'with some fear and trembling' (because of 'a heavy weight of opinion to the contrary' and because the result may be disappointing) that, according to the preceding considerations, it is obvious that there is not yet a genuinely person-centered taxonomy (systematic classification), one that meets the criteria of person-centered anthropology and epistemology described earlier in this paper. Even more: I am not convinced that all the knowledge we have gathered about processes in clients allows us to state that we already know enough about their experiences to elaborate systematic conceptualizations about specific processes.

Diagnosis?

Intrinsically connected with concept-specificity is the question of diagnostics. In the field of medicine rational treatment cannot be planned and executed without an accurate diagnosis, which also means prognosis of likely progress and possible cures and thus prescription of treatment. Such diagnoses are typically stated in terms of symptoms or etiology. For psychotherapy, however, Rogers (1951: 223–5) was convinced that psychological diagnoses are not only unnecessary, but also detrimental and unwise, because they place the locus of evaluation and responsibility in the therapist as the sole expert, which also has long-range social implications for the social control of the many

by the self-selected few. (Again an indication of the social criticism included in his theory and practice.)

Rogers' alternative view sees the client as the expert on their life, because they are the one with the experience: 'Therapy *is* diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician.' (Rogers, 1951: 223; see also his process description of therapy). This shows that the basic problem of diagnosis is the question of who is to be regarded as the experienced one. In a *person*-centered perspective, both are experts, yet in a different sense: the therapist is the expert on not being an expert of the life of another person.

The Greek word 'dia-gnosis' means 'distinguishing judgment'. Diagnosis is the hard work of the client, who works on the process of distinguishing: the client is constantly trying to find out—by experiencing and reflecting—which development is on the agenda next, what they need in the process of personalization. Thus there must be diagnosis, although in a person-centered sense this is differently understood from the common meaning. And though it runs completely counter to the traditional and widespread understanding, from a *person*-centered point of view psychological diagnosis can only be a phenomenological process diagnosis, step by step unfolding through the joint process of experiencing and reflecting by both client and therapist. Just like therapy, diagnosis needs both modes and requires both persons involved in the relationship, thus making it a *co-diagnostic process*.

In summary: Although quite a lot of person-centered 'disorder'-specific knowledge exists and there are phenomenological descriptions that provide a very valuable contribution to person-centered personality and therapy theory, a genuinely person-centered systematic descriptionof inauthentic processes is only rudimentary and a genuinely person-centered taxonomy of process-specificity does not exist at all.

PHILOSOPHY OF SCIENCE: TOWARDS A TRULY HUMAN SCIENCE

So there still is a lot of work ahead. We are not yet able to set up a genuinely person-centered system. Thus the only thing I can provide at this stage in the development of the paradigm is to name criteria such a systematic conceptualization would require. Thus, I state some tentative theses as criteria for a genuinely person-centered conceptualization of different processes of personality development.

1. Conceptions (that is, systems of concepts) must be created on the basis of *personal anthropology*, i.e., on the basis of dialogical or encounter philosophy. Among others this means that conceptions must include thinking in relationship categories as well as in substantial categories. It necessarily includes thinking in processes. The matrix is a conception of personal authenticity, not a concept of dis-*order*, dis-*ease* or the like. Such a conception must be based on growth, a conception that rests on potential

and actualization. Since it will embrace the past and future of the person as well as the present, thus thinking in life-long categories, it will also be of etiological value.

2. Conceptions must be *phenomenological*, i.e., they must go back to the client as a person. Such an approach keeps in mind that what the person shows is relevant and not just what can be analyzed or explained. Person-centered conceptions must be as close to experience as possible, in keeping with the phenomenological radicalism of Rogers.

3. Hence it must be possible to *falsify* the conceptions or parts thereof. Conceptions are useful when they stimulate a process that leads to their being overcome by better ones. It must constantly be possible to revise specific concepts through experience. It is this sort of '*orthopractice*' that always challenges orthodoxy.

4. Conceptions must be *hermeneutic*. The original meaning of hermeneutics applies here: reconstruing the meaning the author of a damaged text had in mind. It also has to be clear that this understanding is ultimately for the client's sake, not for the therapist's; that understanding is impossible without knowledge of the cultural context; and that it is impossible to get rid of all prejudices. The task of existential hermeneutics rather is to become aware of the prejudices and pre-understandings of one's own existence and to make them transparent (see 3).

5. Person-centered conceptions need to be *existential*, i.e., they must have a relation to the whole existence of a person as well as to human existence in general.

6. Conceptions must include *social criticism*. They must have a critical eye on power and control, on interests and expertism; and they have to be emancipatory in nature. Therefore such conceptions must make transparent whose interests they serve and who will benefit from them.

7. Conceptions must trigger *research that is genuinely humanistic* (Rogers, 1964). It goes without saying that person-centered conceptions must allow the influence of empirical research, even if the results are disconfirming. But more important is that person-centered researchers overcome empiricism and positivism and are able to initiate truly person-oriented approaches to research, e.g., intensive case studies or creative types of research such as Elliott's (2002) Hermeneutic Single Case Efficacy Design (HSCED).

CONCLUSION

'Back to the client' means back to the human being. We need a human science to understand what goes on in human beings. If the movement goes from the client to the therapist, then in a client-centered approach we need to go back to the client as the

primary source of knowledge and understanding. Therapy is more than a matter of therapist variables, it is a matter of the client's self-healing capacities. This implies an epistemological paradigm change resulting in a fundamental counter-position to traditional diagnosis and classification: it is the client who defines their life and the meaning of their experiencing and thus 'in-forms' the therapist. The therapist is truly challenged to open up and to risk *the co-creation of becoming (part of) a unique relationship and also*—no less a risk—*to co-reflect on it*.

Why do we have all these discussions and debates about disorder-specific treatment? One main reason is that we want to reply to those who reproach us for not meeting their criteria for scientific work and research, criteria developed by people who start from a completely different view of the human being—if they have a view of the human being at all and not only of some parts or aspects of behavior. If we try to adapt ourselves to those criteria we will lose our identity and abandon the radical paradigm change to the person in the center. We might temporarily gain some applause, but we would lose the reason for being an independent approach, because we would lose our unique stance, the unique offer and ethical challenge of person-centeredness. We would vanish into a general psychology.

The alternative, however, is not an easy task. We face the enterprise of encountering—in the sense of making steps counter to—the mainstream by responding in new categories. We face the job of working hard to develop a human, truly *person*-centered understanding of science, knowledge and research, including genuinely person-centered conceptions of what are called psychological disorders. *We face the challenge of creating an understanding of ourselves beyond the categories of order and disorder*—no less than an uncompromising continuation of the social criticism Carl Rogers pursued with his personality and therapy theory.

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