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Congruent functioning: the continuing resonance of Rogers' theory

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ABSTRACT

Based on a keynote speech at the PCE 2022 conference, this paper responds to the conference theme "How can I be of help?" from the perspective of person-centered therapy. I focus on the kind of help (i.e. the kind of change, or outcome) that clients can expect when participating in person-centered therapy through the lens of "congruent functioning", a contemporary reframing of Rogers' concept of the fully functioning person. This model of congruent functioning was developed from an ongoing research program originally focused on the study of a brief self-report instrument, the Strathclyde Inventory (SI). In this paper, I report findings from this program, including a theoretically coherent hierarchical relationship between SI items identified from the pattern of clients' scoring that may indicate a hypothetical pathway for the development of congruent functioning. I present three different types of supporting evidence for the congruent functioning model, highlighting potential cultural differences, and a case example that considers apparent deterioration in congruent functioning by the end of therapy. Finally, I argue that the model of congruent functioning resonates not only with Rogers' theory concerning the change process underpinning person-centered therapy, but also supports the ongoing commitment to personal development required of person-centered therapists.

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Congruent functioning; fully functioning person; Strathclyde Inventory; self-acceptance; deterioration; therapist development

According to Kirschenbaum (2007), Rogers was often asked to describe his view of the 'healthy person'. His response was his description of the fully functioning person (e.g. Rogers, 1959, 1961, 1963). For Rogers, the fully functioning person embodied an increasingly creative process that facilitated their 'psychological freedom to move in *any* direction' (Rogers, 1961, p. 187). Elsewhere, he wrote:

> It should be evident that the term 'the fully functioning person' is synonymous with optimal psychological adjustment, optimal psychological maturity, complete congruence, complete openness to experience, complete extensionality, as these terms have been defined. Since some of these terms sound somewhat static, as though such a person 'had arrived', it should be pointed out that all the characteristics of such a person are process characteristics. The fully functioning person would be a person-in-process, a person continually changing. (Rogers, 1959, p. 235)

Haugh (2001) noted that all of the characteristics of the fully functioning person proposed by Rogers in his 1959 paper were either definitions or outcomes of congruence.

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Congruence, as a description of psychological health, emerged from the concept of incongruence. Rogers (1951) proposed that psychological tension exists 'when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure' (p. 510). Later, Rogers described this experience of psychological tension as 'a state of incongruence' (1959, p. 213), a 'discrepancy between the actual experience of the organism and the self picture of the individual insofar as it represents that experience' (1957/1992, p. 828), and hypothesized that, as a result of the type of therapeutic relationship that he outlined, the client becomes 'more congruent, more open to his experience, less defensive' (Rogers, 1959, p. 218), noting that the consequence of this increase in congruence was that 'tension of all types is reduced – physiological tension, psychological tension' (p. 218).

In one of his earliest books, Rogers (1942) conceptualized this process as the achievement of insight; a gradual but spontaneous experience occurring through the release of feelings and 'emotionalized attitudes' (p. 216), resulting in a change in perception of relationships, new willingness to accept all aspects of self, and a recognition that a choice of goals exists. When Rogers presented his Nineteen Propositions (1951, pp. 481–533), he described a process in which 'under certain conditions, involving complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences' (1951, p. 517). For him, at that time, congruence was the 'accurate matching of experiencing and awareness' (Rogers, 1961, p. 339).

In 1957, Rogers proposed therapist congruence alongside client incongruence as two of six necessary and sufficient conditions required for therapeutic change to take place. Attention shifted to congruence as an essential quality of the therapist and subsequent literature discussing the concept of congruence has tended to do so from the counselor's perspective (e.g. Wyatt, 2001). In an attempt to synthesize the vast range of ideas about congruence in the original and contemporary literature, Cornelius-White (2007) proposed a five-dimensional model: flow, genuineness, symbolization, authenticity, and organismic integration.

The Strathclyde Inventory

When Freire (2007) set out to develop a self-report measure of therapeutic outcome that was consistent with person-centered theory, she chose to focus on Rogers' concept of the fully functioning person: 'the [hypothetical] end-point of optimal psychotherapy . . . the kind of person who would emerge if counseling was maximal' (Rogers, 1963, p. 18). Freire drew on descriptions of the fully functioning person in Rogers' writing to produce items for the measure that she called the Strathclyde Inventory (SI), named after the university in which she worked at that time.

The SI has developed somewhat organically over the years (Stephen, 2016) and has been translated into French (Zech et al., 2018), Arabic (Alhimaidi, 2019), and German (Bobzien, 2022). The findings discussed in this article are based on data collected in the Strathclyde Counselling and Psychotherapy Research Clinic (University of Strathclyde, Glasgow, Scotland; 'the research clinic') between 2007 and 2016: first using a 31-item version then, from 2012, a 16-item version. The psychometric properties of the SI according to this dataset were reported in Stephen and Elliott (2022) and used to develop a 12-

Table 1. The 12-item Strathclyde Inventory (SI-12).

Items
1: I have been able to be spontaneous
2: I have condemned myself for my attitudes or behavior (R)
3: I have tried to be what others think I should be (R)
4: I have trusted my own reactions to situations
5: I have found myself 'on guard' when relating with others (R)
6: I have listened sensitively to myself
7: I have felt myself doing things that were out of my control (R)
8: I have lived fully in each new moment
9: I have been aware of my feelings
10: I have hidden some elements of myself behind a 'mask' (R)
11: I have felt myself doing things that are out of character for me (R)
12: I have felt it is all right to be the kind of person I am

Notes. Items marked (R) indicate negatively worded items that require to be reverse scored.

item version (SI-12). Ethical approval for the collection, analysis, and reporting of all data presented in this paper was given by the university ethics committee (UEC17/73).

The twelve items that comprise SI-12 are presented in Table 1. Clients are invited to read each statement and consider how often this has been true for them in the last month. They select their response from a 5-point rating scale with the anchor words: never, occasionally, sometimes, often, all or most of the time. The scale is scored from 0 to 4. Six of the twelve items (e.g. item 2 - I have condemned myself for my attitudes or behavior) are negatively framed and therefore reverse scored. Contrary to most outcome measures, which focus on reducing symptoms of distress, higher scores on the Strathclyde Inventory indicate a higher degree of psychological wellbeing. Stephen and Elliott (2022) advised that the SI can be considered unidimensional and recommended that clients' scores are calculated as total mean scores.

The research clinic functions as a community counseling service offering free medium- to long-term therapy to people living in our local area. We are open to clients who want to work with a whole range of experiences, positioning ourselves as a generic counseling service. Table 2 provides an overview of client demographic data for the datasets reported in this paper. The table also reports categorization (where this is available) of the type of difficulties reported by clients at the beginning of therapy for the purpose of constructing a client-generated outcome measure, the Personal Questionnaire (Elliott, Stephen et al., 2016, Elliott, Wagner et al., 2016). We ask clients to participate in research activities throughout their counseling: that is, completing questionnaires before and after sessions, and taking part in regular research interviews. We encourage clients to review their consent to the way in which their data is used by the research clinic at regular intervals during their counseling and to re-confirm at the end. All clients whose data is reported in this paper have given informed consent for their data to be analyzed and disseminated in this way. Clients work with therapists and researchers who are usually students of our postgraduate training in person-centered therapy. Table 3 provides therapist demographic data for the datasets in which client outcome is reported.

The SI is one of three outcome measures that we use; clients complete the SI before they begin therapy, after every 10 sessions, and at the end of therapy. I will explain how we used the SI data collected at the research clinic to develop a model that I have called

Table 2. Client demographics by dataset.

	Dataset											
	N = 225		*N* = 39		*N* = 216		*N* = 192		*N* = 4 (Imp)		*N* = 4 (Det)	
	N	%	N	%	N	%	N	%	N	%	N	%
Gender												
Male	80	35.6	19	48.7	79	36.6	67	34.9	2	50	2	50
Female	144	64.0	20	51.3	137	63.4	117	60.9	2	50	2	50
Non-binary	1	0.4	-	-	-	-	1	0.5	-	-	-	-
Not recorded	-	-	-	-	-	-	7	3.6	-	-	-	-
Age												
Mean (in years)	35.1		38.6		36.3		31.5		41.5		24.5	
Median (in years)	33		40		35		27		46.5		24.5	
Mode (in years)	23		51		31		23		-		-	
Range (in years)	18 - 66		18 - 56		18 - 67		18 - 77		23 - 50		18 - 31	
Not recorded	7	3.1	2	5.1	1	0.5	24	11.1	-	-	-	-
Ethnicity												
Asian (Indian)	2	0.9	-	-	1	0.5	1	0.5	-	-	-	-
Asian (Pakistani)	2	0.9	-	-	4	1.9	-	-	-	-	-	-
Asian (Chinese)	-	-	-	-	-	-	4	2.1	-	-	-	-
Black (African)	2	0.9	-	-	1	0.5	1	0.5	-	-	-	-
Black (Caribbean)	-	-	-	-	-	-	1	0.5	-	-	-	-
White (British/European)	215	95.6	35	89.7	191	88.4	140	72.9	4	100	4	100
Other	4	1.8	4	10.3	17	7.9	37	19.3	-	-	-	-
Not recorded	-	-	-	-	2	0.9	8	4.2	-	-	-	-
PQ item categories												
Interpersonal	114	50.7	19	48.7	85	39.4	-	-	3	75	4	100
Trauma	8	3.6	2	5.1	6	2.8	-	-	-	-	-	-
Self-related	108	48.0	18	46.1	74	34.3	-	-	3	75	4	100
Life functioning	61	27.1	11	28.2	31	14.4	-	-	3	75	2	50
Depression	51	22.7	12	30.8	26	12.0	-	-	1	25	1	25
Emotion	24	10.7	6	15.4	27	12.5	-	-	-	-	-	-
Self-damage	4	1.8	1	2.6	4	1.9	-	-	-	-	-	-
Anxiety	60	26.7	14	35.9	31	14.4	-	-	-	-	-	-
Not yet categorized	26	11.6	2	5.1	-	-	192	100	-	-	-	-
Social anxiety study	-	-	-	-	58	26.9	-	-	-	-	-	-
Number of PQ categories per client												
0	26	11.6	6	15.4	26	12.0	-	-	-	-	-	-
1	40	17.8	9	23.1	42	19.4	-	-	1	25	-	-
2	58	25.8	7	17.9	50	23.1	-	-	1	25	2	50
3	37	16.4	6	15.4	23	10.6	-	-	1	25	1	25
4	29	12.9	5	12.8	13	6.0	-	-	1	25	1	25
5	7	3.1	2	5.1	3	1.4	-	-	-		-	-
6	2	0.9	2	5.1	1	0.5	-	-	-		-	-

Note. Imp = improver; Det = deteriorator. PQ = Personal Questionnaire. PQs created since 2016 and those of clients in specialist social anxiety study not yet categorized.

'congruent functioning'. Why 'congruent functioning'? I find the term 'fully functioning' awkward when talking about relative degrees (i.e. being more or less fully functioning). As the fully functioning person is synonymous with congruence, this offered an alternative term. However, as Grafanaki (2013) noted, congruence is often represented as if it is a state (i.e. a trait or a characteristic), not a process. Therefore, I adopted a hybrid term – congruent functioning – to bring together these two synonymous terms, while emphasizing their processing, non-static, nature. In doing so, my intention was not to introduce a new term but to claim an alternative term that is already present in the literature, for example, Mearns (1997) used the term when discussing the personal development work required of trainee person-centered counselors.

Table 3. Therapist demographics by dataset.

	Dataset							
	N = 225c		*N* = 39		*N* = 4 (Imp)		*N* = 4 (Det)	
	N	%	N	%	N	%	N	%
Total N therapists[1]	62	100	35	100	7	100	8	100
N clients: 1 change of therapist	53	23.6	14	35.0	1	25	4	100
N clients: 2 changes of therapist	11	4.9	3	7.5	1	25	-	-
Gender								
Male	11	17.7	6	17.1	1	14.3	1	12.5
Female	51	82.3	29	82.9	6	85.7	7	87.5
Estimated age when joined clinic								
Mean (in years)	34.1		35.3		36.0		38.4	
Median (in years)	31		33		39		35	
Mode (in years)	25		23, 28		23		-	
Range (in years)	22 - 58		23 – 58		23 - 55		23 – 58	
Ethnicity								
Asian (Pakistani)	1	1.6	1	2.9	-	-	-	-
Asian (Chinese)	2	3.2	1	2.9	-	-	-	-
White (British)	36	58.1	22	62.9	7	100	4	50
White (European)	15	24.2	7	20.0	-	-	3	37.5
Other	8	12.9	4	11.4	-	-	1	12.5
Professional status when joined clinic								
In training	52	83.9	31	88.6	7	100	8	100
<3 years post-qualification	3	4.8	1	2.9	-	-	-	-
<10 years post-qualification	7	11.3	3	8.6	-	-	-	-

Note. [1]As the research clinic operates with therapists in training, some clients experience a change of therapist during their therapy when the therapist's placement ends.

In this paper, I describe how a model of congruent functioning was developed from Rogers' work using contemporary data collected in our research clinic. I will begin by reporting our findings to the question: do clients change in therapy according to their SI scores? Next, I will present the model of congruent functioning derived from our dataset, with three different types of supporting evidence. Finally, I will explain why I think developing and maintaining our own congruent functioning is the key challenge for person-centered therapists.

Do clients change in therapy according to their Strathclyde Inventory scores?

As Stephen and Elliott (2022) reported, clients do appear to change in therapy according to their Strathclyde Inventory data. In that study, we analyzed SI data collected at the beginning and end of therapy from 225 clients who attended 3–70 sessions (mean = 25.2; median = 23; mode = 40) at the research clinic. Our answer was yes: the change in their mean scores by the end of therapy was large (Cohen's $d = .93$) and statistically significant. However, I was interested in the shape of this change (Stephen, 2020). I had a hypothesis: that, at least for some clients, SI scores may decrease before they increase as clients become more self-aware and able to more accurately discern their experience.

I used a repeated-measures ANOVA to test the SI data collected from a sub-sample of 39 clients who had attended at least 40 sessions of counseling. Figure 1 presents the mean SI scores across data collection points, with 95% confidence intervals and a line

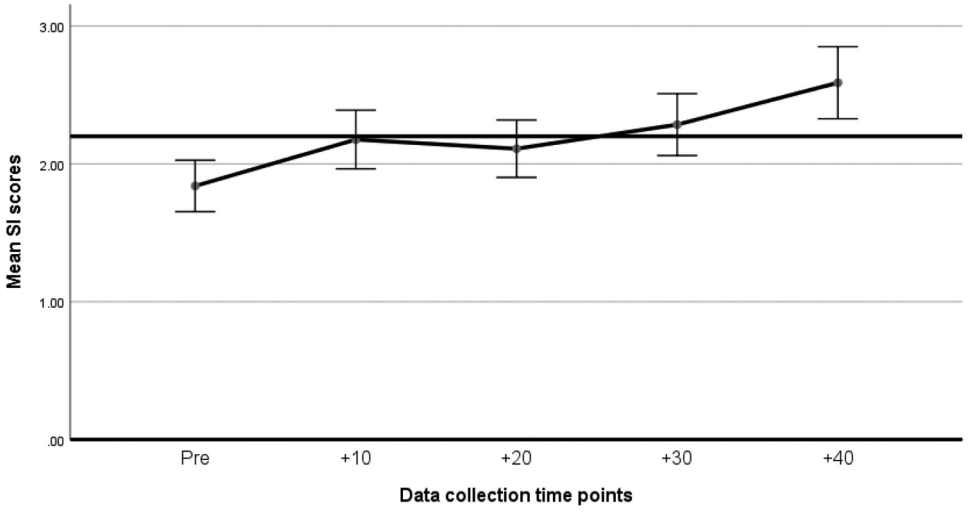

Figure 1. Line graph of mean SI scores across therapy for 39 participants who completed 40 sessions. Notes: Pre-therapy (M = 1.87; SD = .55); after 10 sessions (M = 2.22; SD = .61); after 20 sessions (M = 2.15; SD = .59); after 30 sessions (M = 2.33; SD = .66); and after 40 sessions (M = 2.62; SD = .80). Error bars = 95% confidence intervals. Black horizontal line = grand mean.

Table 4. Tests of within-subjects contrasts between five SI data collection time points.

Source	Contrasted data collection points		Type III Sum of Squares	*df*	Mean Square	*F*	Sig.	*d*
Data collection points	Pre-therapy	+10 sessions	4.786	1	4.786	18.736	.000**	.60
	+10 sessions	+20 sessions	.183	1	.183	1.175	.285	.12
	+20 sessions	+30 sessions	1.165	1	1.165	4.910	.033*	.29
	+30 sessions	+40 sessions	3.450	1	3.450	13.410	.001*	.40
Error	Pre-therapy	+10 sessions	9.707	38	.255			
	+10 sessions	+20 sessions	5.913	38	.156			
	+20 sessions	+30 sessions	9.015	38	.237			
	+30 sessions	+40 sessions	9.777	38	.257			

Notes. +10 = after 10 sessions; +20 = after 20 sessions; +30 = after 30 sessions; +40 = after 40 sessions. ** $p < .001$; * $p < .05$.

depicting the grand mean. Mauchly's test indicated that the assumption of sphericity (i.e. that there were equal variances across all levels of the repeated measures ANOVA) had been violated, $X^2(9) = 33.41$, $p = .000$, therefore, Greenhouse-Geisser corrected tests are reported ($\varepsilon = .68$). The results show that the data collection point had a significant, moderate effect on participants' SI scores, $F(2.7,102.98) = 16.4$, $p < .001$, $\omega^2 = .07$. An analysis of within-subjects contrasts (Table 4) identified statistically significant differences between each data collection point except between 10 and 20 sessions, with a medium-large effect after the first 10 sessions ($d = .60$); a small effect after the next 10 sessions ($d = .12$); a small-medium effect after the next 10 sessions ($d = .29$), and a medium effect after the final 10 sessions ($d = .40$).

This apparent plateau during the mid-therapy period could be interpreted as a period of no change but more likely it represents a variety of different trends in the data – some clients' scores increasing, while others decreased – that were offset when the data was aggregated. The ongoing improvement in scores following the plateau provides evidence of the potential value in longer-term therapy for some clients. This pattern has been found elsewhere, for example in the 'early and late change' trajectory noted by Owen et al. (2015).

I tested this further by conducting a multilevel linear analysis of the whole dataset (all 225 clients) an analysis that can accommodate the differing number of data collection points resulting from the different therapy durations. The analysis modeled a two-level hierarchical data structure: participants (level 2) and their score at each data collection point (level 1). I found that a cubic polynomial model (that is, two points of change) was the best fitting model for the data and again indicated that the data collection point significantly predicted SI scores, $F(1, 354.62) = 12.1$, $p < .01$. In other words, the later in the therapeutic process the SI data was collected, the higher the score.

Conversely, this analysis also confirmed that, although there was a general trend in the data that could be represented by this model, there was significant variance in intercepts (i.e. pre-therapy scores) across participants ($\text{Var}(u_{0j}) = 0.28$, SE = .04, $p < .001$), and between participants' slopes ($\text{Var}(u_{1j}) = 0.03$, SE = .01, $p < .01$). This provided evidence of heterogeneity in the shape of client change recorded by the SI over time.

Therefore, we found that clients participating in person-centered therapy at the research clinic did increase in the type of functioning described by Rogers, according to their SI scores, and that this was not necessarily a linear process. As one might expect, there was considerable variety in the shape of our clients' change.

What type of experiencing does the Strathclyde Inventory capture?

We wanted to explore more closely the nature of the construct being measured by the SI. In Stephen and Elliott (2022), we analyzed the pattern of scoring in our SI dataset and reported a theoretically coherent hierarchical relationship between the items. Table 5 presents this hierarchical relationship in which the items comprising the SI-12 are clustered into six groups, each with a proposed description, ranging from least difficult (self-awareness) to most difficult (fully functioning; i.e. optimum congruent functioning).

To be clear, these item groups are not factors or dimensions within the instrument. Stephen and Elliott (2022) demonstrated that the SI can be treated as unidimensional. This pattern in our clients' scoring of SI items can be understood as a hierarchical relationship between items. It may also indicate a progressive relationship; a hypothetical pathway for the development of congruent functioning:

Table 5. Hierarchical relationship between SI-12 items.

Proposed description	Items
Fully functioning (most difficult)	8: I have lived fully in each new moment
Openness to others	5: I have [not] found myself 'on guard' when relating with others
	10: I have [not] hidden some elements of myself behind a 'mask'
Openness to self	2: I have [not] condemned myself for my attitudes or behavior
	1: I have been able to be spontaneous
Self-acceptance	6: I have listened sensitively to myself
	12: I have felt it is all right to be the kind of person that I am
Self-trust	3: I have [not] tried to be what others think I should be
	4: I have trusted my own reactions to situations
Self-awareness (least difficult)	7: I have [not] felt myself doing things that were out of my control
	9: I have been aware of my feelings
	11: I have [not] felt myself doing things that are out of character for me

Note. Items that are reverse scored are formatted with [not] so that all statements indicate growth in the same direction.

- the more self-aware I am, the more able I am to trust my experience
- the more able I am to trust my experience, the more able I am to accept myself;
- the more self-accepting I am, the more I am able to be open to myself and my experiencing;
- and the more open I am to myself, the more open I can be toward others.

It is important to emphasize that this is a hypothesis based on findings from a relatively small dataset. A larger dataset would permit this hypothesis to be tested by more sophisticated analyses. Furthermore, this pattern in scoring was detected in a dataset consisting of hundreds of observations and is not recommended as a way of evaluating or interpreting an individual client's score.

Conceptualizing congruent functioning

I propose two alternative ways to conceptualize congruent functioning. From one perspective, congruent functioning might be viewed as an emergent process, sequentially expanding from self-awareness to encompass self-trust, self-acceptance, openness to self, and ultimately openness to others (Figure 2(a)). However, this might suggest a unidirectional – perhaps even one-off – experience. Rogers proposed that the fully

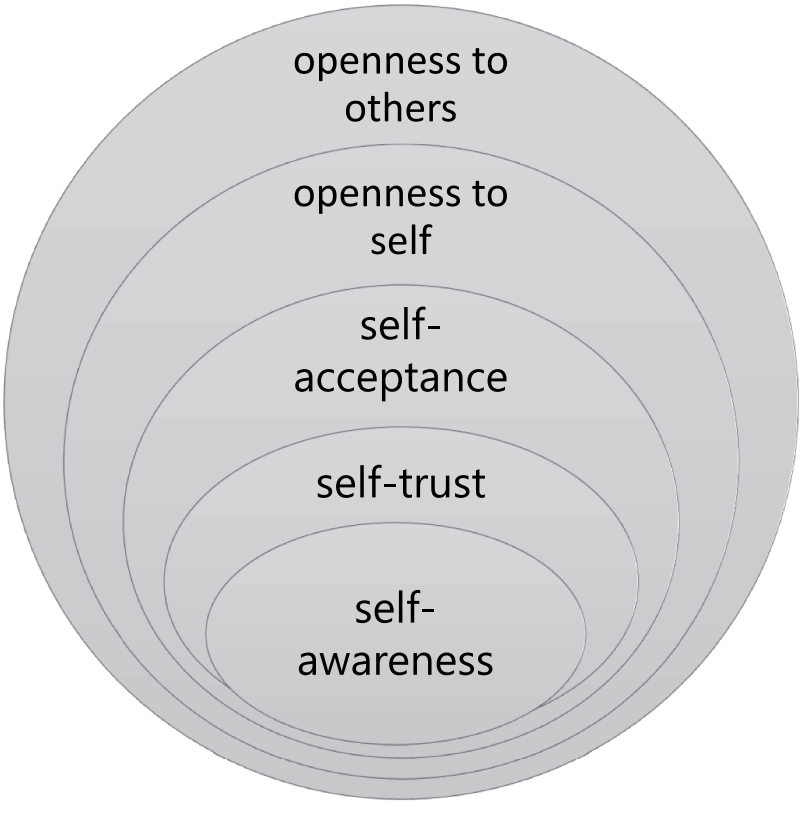

Figure 2a. Emergent model of congruent functioning.

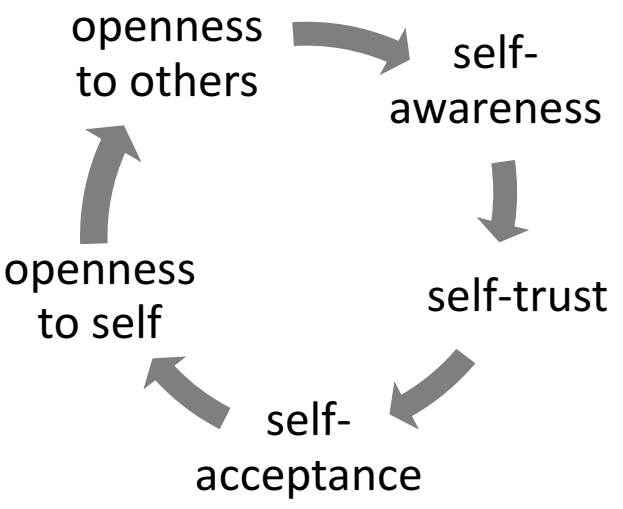

Figure 2b. Cyclical model of congruent functioning.

functioning person was a process, a person in motion. Therefore, the cyclical model presented in Figure 2(b) offers an alternative visual representation of the concept of congruent functioning that may be a closer fit. It makes sense to view congruent functioning as an ongoing process: as we become more open to ourselves and to others, we are more likely to experience unexplored aspects of our selves-in-relationship coming into our awareness, a continuing process of integration.

This seems to be what Rogers was describing in his commentary on a letter he received from a woman following her transformative experience at a large group encounter:

> There is a peaceful harmony in being a whole person, but she will be mistaken if she thinks this reaction is permanent. Instead, if she is really open to her experience, she will find other hidden aspects of herself that she has denied to her awareness, and each such discovery will give her uneasy and anxious moments or days until it is assimilated into a revised and changing picture of herself. She will discover that growing toward a congruence between her experiencing organism and her concept of herself is an exciting, sometimes disturbing, but never-ending adventure. (Rogers, 1980, p. 214)

Supporting evidence for the congruent functioning model

Next, I present three pieces of evidence that appear to support the proposed model of congruent functioning.

Replication in new dataset

The first piece of supporting evidence is that this hierarchical relationship between items was replicated when I carried out the same analysis with a new set of SI data collected from 192 clients at the research clinic since 2017. I conducted differential item functioning (DIF; Bond & Fox, 2015) to test for any differences between the functioning of items in the

Table 6. Differential item functioning contrasting two SI datasets collected in research clinic.

	Research Clinic #1 (N = 216)		Research Clinic #2 (N = 192)		Differential Item Functioning (Rasch-Welch)			
Item	Measure	S. E.	Measure	S. E.	DIF contrast	t	d.f.	Prob.
1	.29	.08	.17	.08	.13	1.09	398	.2759
2	.42	.08	.47	.08	−.06	−.49	398	.6223
3	−.04	.08	.03	.08	−.07	−.57	398	.5715
4	−.11	.08	−.11	.08	.00	.00	397	1.000
5	.77	.08	.48	.08	.29	2.43	400	.0154
6	.14	.08	.14	.08	.00	.00	398	1.000
7	−.83	.08	−.83	.09	.00	.00	398	1.000
8	1.05	.09	.90	.09	.14	1.16	398	.2462
9	−1.05	.09	−.93	.09	−.12	−.97	397	.3339
10	.48	.08	.48	.09	.00	.00	397	1.000
11	−1.23	.09	−.89	.09	−.34	−2.71	396	.0070
12	.11	.08	.11	.08	.00	.00	394	1.000

Notes. Research Clinic #1 = dataset collected 2007 – 2016. Research Clinic #2 = dataset collected 2017–2022.

two datasets and found no DIF contrasts of interest (i.e. at least 0.5 logits and with probability $p < .05$; Linacre, 2011). Table 6 presents the results of this analysis.

However, it is possible that this finding may not replicate in other cultural contexts. Our participants are representative of – and limited to – a particular cultural context and setting: predominantly White females living in the west of Scotland, willing to access therapy offered within a university campus, and to take part in research activities. Stephen, Alhimaidi, et al., 2022) was a pilot study in which we used DIF in a secondary analysis of the data that we had previously collected for our individual studies of different language versions: a 20-item Arabic-language version (Alhimaidi, 2019), a 20-item English-language version (Stephen, Elliott, et al., 2022) and a 22-item French-language version (Zech et al., 2018). We found at least one DIF contrast of interest in 11 of the 18 items shared by the three versions of the SI used within our independent studies. This suggested that these items may be functioning differently across our datasets. We explored our results together – each as insiders of our own cultures – and identified potential explanations relating to culture, linguistics, and the context and circumstances of our participant groups. We plan to collect new data to continue this exploration. It is quite possible that we will find that the model of congruent functioning presented here does not fit other cultures, giving us the opportunity to contribute to the development of an expanded, more inclusive theory of person-centered therapy that encompasses our cultural differences.

Client testimony

One difference identified by Stephen, Alhimaidi, et al., 2022 was that Scottish participants appeared to find two SI items more difficult than Saudi Arabian and French-speaking Belgian participants. These two items (I have been able to be spontaneous; I have lived fully in each new moment) connect to the second piece of supporting evidence. Quite by chance, when checking an audio recording for a different purpose, I discovered a research clinic client discussing these two SI items in an end of therapy research interview. When asked about his experience of being involved in the research, the client (whom we called 'Jamie') said:

> Some [questionnaires], like the Strathclyde Inventory one, there were things like . . . about like being spontaneous and things like that, where I didn't really think . . . were . . . they almost didn't feel like they applied to me at the beginning because I really wasn't a spontaneous person. But now I can see how . . . that after counseling you would want to feel more . . . trying new things . . . and be more or take more opportunities like that . . . And also there's one about . . . something new moment in each new day . . . something like that [. . . .] Yes, it's like something to aspire to, I think. Maybe I'm not always doing it but it makes me feel that there's kind of room once you start going down this path of personal growth, there's more room to grow.

This was a serendipitous find – a client speaking about their own experience of these two items, pinpointing not only why, at first, they had struggled to relate to these items, but also explaining that at the end of their therapy they had become much more open to the type of experience suggested by these items. It is also quite unusual, in our experience, for a client to talk in such detail about one of the standardized instruments.

Mapping qualitative changes to the model

The third piece of supporting evidence that I want to share involves the changes by the end of therapy described qualitatively by eight of our 225 clients, which we explored through a series of systematic case studies. I selected four clients whose SI scores at the end of therapy indicated reliable improvement since pre-therapy ('improvers') and four clients whose SI scores at the end of therapy suggested reliable deterioration ('deteriorators'). Eight Masters students were each assigned one of these clients then collated the diverse range of quantitative and qualitative data collected during these clients' therapy to produce a 'rich case record' that was analyzed and evaluated using the Hermeneutic Single Case Efficacy Design method (HSCED; Elliott, 2002). Next, I carried out a metasynthesis of the material generated by the eight case studies to identify and compare categories of qualitative data relating to in-session processes (reported in Stephen, Bell, et al., 2022) and changes (Stephen, 2020). The metasynthesis was carried out using a generic descriptive-interpretive qualitative approach (Elliott & Timulak, 2021). More information about the method and clients (improvers – 'Linda', 'Julia', 'Simon' and 'James'; deteriorators – 'Luke', 'Sophia', 'Joseph' and 'Caitlin') is reported in Stephen, Bell, et al. (2022).

The congruent functioning model was not used to categorize the qualitative changes identified in the series of case studies but the findings could map onto the model. It should also be noted that, as we use Elliott's et al. (2001) semi-structured Change Interview, clients are specifically encouraged to tell their researcher about anything that has changed for the worse since therapy started, as well as anything that they had wanted to change that has not changed. Table 7 presents the categories constructed from the data, organized in two higher order categories: Relationship with Self; and Self in the World.

Relationship with self

We found evidence that all clients experienced increased self-awareness and self-understanding, which included becoming more aware of their needs and their impact. For example, Linda described being 'more aware of where my feelings are coming from',

Table 7. Qualitative changes experienced by improvers and deteriorators by the end of therapy and reported in a series of eight case studies.

Qualitative changes	Improvers (N = 4)	Deteriorators (N = 4)
Relationship with self		
Increased self-awareness/self-understanding	4	4
More aware of needs & their impact	4	3
Increased self-acceptance	4	2
More self-compassion	4	2
Increased appreciation of self	3	0
Feeling complete/more integrated/back on track	4	2
Increased self-control/stillness/calm	3	1
More access to emotions	1	1
More in touch with embodied self	1	0
Self in the world		
More empowered/motivated	4	2
Increased self-confidence/self-trust/self-belief	3	1
New understanding of self in relationship	3	2
Less fearful of rejection and abandonment	3	1
Able to deal with conflict in relationship	1	1
More able to put own needs first in relationships	2	1
Able to ask for needs to be met	1	0
Setting limits	1	0
Able to make choices for self	0	1
Increased awareness of impact on/of self in relationship	2	0
Figuring out who/how to trust	1	0
Increased openness	4	1
To dealing with life as it comes	3	0
Some things not in control	3	0
To connecting with other people	2	1
More accepting of others' differences	1	1
To being in the moment	2	0
To taking risks/challenging self	1	0
More positive/balanced/realistic perspective on life	3	0

and Julia realized that 'where being a little hard on myself used to motivate me, it only makes me feel worse now that the reason I'm being hard on myself is more personal'. Meanwhile, Luke told his researcher at his second change interview that therapy was helpful because 'he had become more aware'.

For improvers, this change in their relationship with self expanded beyond self-awareness and self-understanding. They appeared to develop increased self-acceptance, characterized by more self-compassion and increased appreciation of self. Simon, reflecting at the end of session 33, commented: 'this felt good because I was able to flow a bit more than usual, and used time wisely as I have with other aspects of my life'; while James told his researcher:

> It's okay to be me and where and how I am [. . .] I feel freer to be me, freer to be happy [. . .] I think, somehow, I used to feel that I oughtn't to be happy. I had a lot of shame and guilt, um, which was really unwarranted.

Improvers also described themselves as feeling complete, more integrated, and 'back on track', typically experienced as increased self-control, stillness, or calm. Julia reported: 'I feel like I am back to me', and James noticed that: 'My body feels less anxious, less uncertain, abandoned. I feel happier now that I'm more integrated in my body'.

Self in the world

We noted that all clients experienced some degree of change in relation to their self in the world. However, there was more consistency in the nature of the reported changes amongst improvers than deteriorators. All improvers reported feeling more empowered or motivated, typically characterized as increased self-confidence, self-trust, or self-belief. For example, James remarked that: 'Piecing things together has an illuminating and empowering effect', and Julia reported that she felt more confident in public speaking and social interaction. Simon noted that he believed in himself more, writing: 'I feel I want to move forward and, now that my head and heart [are] clearer, make a detailed plan and take action'

Most improvers described a new understanding of self in relationship in which they felt less fearful of rejection and abandonment. Linda's HSCED researcher noted that Linda had described positive changes throughout therapy that related to this theme, which she had identified in her Personal Questionnaire as one of her longest standing problems. Meanwhile, all improvers noticed feeling an increased openness toward the world, especially to dealing with life as it comes, and a more positive, balanced or realistic perspective on life. James commented: 'It's not always changing at the right rate or direction. I'm much more content now to just be myself. I think that it doesn't really matter what happens, I can deal with it', while Julia reported 'a more positive outlook on everything', and Simon described his counseling as 'helping me to be more realistic, and move on and look forward to life rather than fear it'.

To summarize, all eight case studies provided evidence that the client had increased in self-awareness during therapy, but only the case studies focused on the improvers provided consistent evidence of increased self-trust, self-acceptance, and openness to being themselves in the world. We could say that the deteriorators reported changes at the end of therapy that reflected congruent functioning at a relatively early stage of development. In contrast, the changes reported by improvers were more aligned with an expanded experience of congruent functioning, following the general trend proposed by the congruent functioning model, while overlapping, intertwining and elaborating the descriptions provided by the items themselves. Future research is required to test this finding, which should include following up with clients months and years after the end of therapy to investigate the extent to which these changes endure.

Self-acceptance: the pivot point in congruent functioning

This finding highlights self-acceptance – or unconditional positive self-regard (Bozarth, 2001a) - as the potential pivot point in the process of congruent functioning. It seemed that deteriorators ended therapy at a point at which, paradoxically, they were capable of greater congruent functioning (i.e. self-awareness) than when they started but were unable to move through this process sufficiently to gain the self-acceptance that was experienced by the four improvers.

Indeed, if – as Bozarth (2001b) has argued – the therapist's unconditional positive regard is the 'curative variable in [person]-centered therapy' (p. 5), these results support the premise that it is the client's reciprocal development of self-acceptance that is the curative experience. This corresponds with Roger's (1959) theory that reducing self-discrepancy is a mechanism for change, and is consistent with the results of Watson's

et al. (2014) study of change in self-discrepancy, anxiety and depression over the course of therapy. There is also a clear link with self-compassion, described by Neff et al. (2018, p. 627) as 'the balance between increased positive and negative self-responding to personal struggle [that] entails being kinder and more supportive toward oneself and less harshly judgmental'. Neff and colleagues' research has consistently demonstrated a relationship between self-compassion and psychological well-being (e.g. Neff et al., 2017, 2018; Neff, 2003).

Furthermore, self-acceptance as a mediator for increasing congruent functioning complements the concept of emotional transformation, the model of change underpinning emotion-focused therapy (Elliott et al., 2004). Pascual-Leone (2018) depicted emotional transformation as a developmental movement from global distress to acceptance and agency, by working through maladaptive emotions (e.g. rejecting anger and shame/fear), enabling negative self-evaluations and unmet existential needs to be expressed, and producing a 'categorically new experience [that leads] the client to a sense of "Self as deserving" and mobilizes her or him to directly address unmet needs' (Pascual-Leone, 2018, p. 168), that results in a sense of closure or resolution. I suggest that these two models intersect at the pivot point of self-acceptance, with the emotional transformation model focused on the process of developing self-awareness, and the congruent functioning model illustrating the development of agency through growing openness to self and others.

As a result, I believe that the model of congruent functioning strengthens the link between Rogers' original theory and contemporary psychotherapy research through the significance of self-acceptance within the process of therapeutic change. However, I would like to go further by also considering the implications of congruent functioning for the practice of person-centered therapists.

Openness to self *before* openness to others

The congruent functioning model suggests that openness to others is more possible for those who are already open to themselves. This finding is striking because it fits so clearly with the process described in Rogers' 19 Propositions, specifically captured in Proposition 18 as: 'When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others and is more accepting of others as separate individuals' (Rogers, 1951, p. 520).

This is an important point for therapists. It suggests that to be as open as possible to our clients, we must strive to be as open as possible to ourselves. It is consistent with Bozarth's (2001a, p. 197) assertion that '[therapist] congruence is the manifestation of unconditional positive self-regard' and explains why it is essential that person-centered (indeed, in my opinion, all) therapists commit to developing and maintaining their own congruent functioning. Evidence of the importance of this commitment is highlighted next.

How can I *not* be of help? A potential process of deterioration

In Stephen, Bell, et al. (2022) we categorized and compared the in-session processes in systematic case studies of the therapeutic experiences of four improvers and the four

deteriorators. We found clear similarities *within* the two groups, and differences *between* them, enabling us to identify three key aspects that may shed light on a potential process of deterioration in person-centered therapy.

First, the deteriorators appeared less ready to begin therapy than the improvers. Although deteriorators were motivated to begin, they arrived with doubts about the process (e.g. that they would feel more vulnerable) or other expectations that had the potential to result in doubt about the process (e.g. that their counselor would give them advice).

Second, these doubts (or potential for doubt) seemed to be confirmed in the process. Deteriorators reported experiencing discomfort, including difficulty opening up, being unable to find direction, deferring to their therapists, and disengaging in various ways.

It seems likely that the deteriorators' therapists were unable to respond sufficiently to their clients' doubts and discomfort as therapy proceeded. We found evidence that, while their therapists attempted to validate and affirm deteriorators' experiences, they appeared at times to resort to working outside of their client's frame of reference, including acting in a manner that could be described as controlling or directive. For example, Joseph described his counselor as wanting to 'delve' into details about his family, and told his researcher: 'that's not what's upsetting me, that's not why I'm here'. In another example, we found that Luke's therapist had written in their session notes on several occasions that they had 'created' silence as an 'opportunity' for Luke to engage in his therapy. However, this was not how Luke perceived these experiences. He told his therapist that, for him, these periods of silence were a sign of being abandoned, a lack of caring.

Indeed, this was just one example of the disconnect between Luke and the two different therapists he worked with during his time at the research clinic (Love, 2018). Luke was in his late teens. He had emigrated to Scotland with his parents some years earlier and was now a university student. He came to therapy at the research clinic because he was struggling in social situations, and was isolated. Luke attended 55 sessions over 15 months, working with his first therapist for 27 sessions, then with a second therapist for a further 28 sessions. Despite self-referring, Luke was doubtful that therapy would help him, and struggled to talk in sessions. He seemed disengaged from his own experience. Later, he wrote to his second therapist: 'When I try to talk about such things it feels to me as if I was somebody else's story'.

According to Love (2018), both of Luke's therapists appeared to find it extremely difficult to remain open to him and his way of being. Luke's first therapist considered ending the therapy almost from the beginning, then appeared to use the prospect of ending as a way to encourage engagement, writing in their session notes:

> Session 2: 'I won't end this, it's [his] choice'
>
> Session 7: 'I am doing too much of the work here'
>
> Session 14: 'focusing on the possibility of ending to encourage him to engage'
>
> Session 17: 'I spoke again about the likelihood of ending in the next few sessions'
>
> Session 20: Therapist made decision to resume therapy.

When this therapist ended their placement at the clinic some weeks later, a new therapist was assigned to work with Luke. They seemed to fall into a similar cycle although attempting more creative ways to engage with Luke:

> Session 28 (their first session): 'I told him . . . he could be the way he wanted to with me'
>
> Session 34 'I do prefer to demand that he does something'
>
> Session 35: 'I tried describing how he was reacting to keep the session close to his process and less led by me'
>
> Session 42: Therapist made origami while they sat in silence.
>
> Session 44: 'I talked a lot . . . I had told him I didn't want to talk in sessions'

Based on the descriptions contained in the therapists' notes, Love proposed a narrative to capture Luke's therapists' process, which she called a 'cycle of therapist inconsistency': one of acceptance, frustration, attempts to motivate, withdrawal, and re-engagement. It makes sense that this inconsistency would feed a process of deterioration:

- the more that the client struggles, the more the therapist will doubt their capacity to work with this client, or feel frustrated;
- and the more the therapist struggles, the more the client's doubts will be confirmed, and the more discomfort they will feel.

From the perspective of person-centered theory, we can see that this process of deterioration would undermine the conditions required for therapeutic change to occur (Rogers, 1959). The therapist's doubt and frustration can be understood as an expression of painful self-awareness, perhaps a fear that they cannot be of help to this client and perhaps a fear of judgment from the client, their peers or supervisor. Indeed, this may be so: the therapist (or therapy) may not be the right fit for this particular client because of the source or quality of the client's incongruence (Speierer, 2013). Without exploring this possibility (e.g. in supervision), we can imagine the potential implications that this might have for the therapist's self-acceptance (and therefore congruence). It is no wonder that the therapist might withdraw from their client, perhaps even become out of psychological contact. Certainly, their capacity for empathic understanding and unconditional positive regard for their client would be limited, given that congruence is the 'delivery system for unconditional positive regard and empathy' (Von Glahn, 2018, p. 46), and therefore unlikely to be perceived by their client.

This takes us back to the congruent functioning model: as therapists, we can only be as open to others, as we are able to be self-aware and to trust, accept and be open to ourselves. As Rogers wrote:

> . . . the degree to which I can create relationships which facilitate the growth of others as separate persons is a measure of the growth I have achieved in myself. In some respects this is a disturbing thought, but it is also a promising or challenging one. It would indicate that if I am interested in creating helping relationships I have a fascinating lifetime job ahead of me, stretching and developing my potentialities in the direction of growth. (Rogers, 1961, p. 56)

The challenge for person-centered therapists

However, healthcare policy, at least in some countries (e.g. Du et al., 2021), promotes the idea that technology can solve our psychological problems. In the research clinic, we notice that our clients often arrive in therapy with expectations of the expert provision of a quick and painless 'fix'. How do we respond as person-centered therapists who seek to be as open as possible to our clients yet hold our own expectations about how change is likely to occur?

I believe that our way of helping is to *meet* our clients in their expectations, but not necessarily to change what we do in order to *match* those expectations. From the perspective of person-centered theory, it is not therapeutic to match our client's incongruence with our own. Instead, I want to enter into my client's frame of reference, holding true to the possibilities of this encounter by listening deeply to my client's fears and doubts – their way of making sense of the world – in a way that enables them to feel heard and understood. In this moment, *this* is our work, the focus for our therapy. Experiencing my understanding may provide my client with the positive regard (Ort et al., 2022) they need to encourage them to move into relationship with me. At the same time, the more I understand my clients' fears and doubts, the more sensitive I can become to them and more able to respond when they emerge within our work together.

How do we sustain ourselves in this process? The therapists interviewed by Kaimaxi and Lakioti (2021) described the development of congruence as a 'life-lasting ongoing process . . . that needs active and constant care on multiple levels' (p. 232) in particular within supportive relationships. In other words, we need to deliberately nurture our own congruent functioning within relationships. O'Hara and Leicester (2018, p. 162) argued that there can be 'no solo climbers' (p. 162) as we develop the competences required to thrive in complexity of the 21st century: we cannot do this on our own. We must take the initiative to find our people, the ones who can let us be ourselves, our messy, vulnerable, imperfect, beautiful selves. The ones who share our values – well enough – to be enthused and support us in our endeavors. The ones who challenge us to acknowledge and explore the parts of ourselves that often we prefer to hide. We must be deliberate in making time to be with our people; perhaps they are friends and family; perhaps our peers or supervisor; perhaps they are the like-minded people we meet in encounter groups and conferences. We might never meet in person, but the connection that we have is real. When we find our people, then we can be ourselves; our congruent functioning will flow. We can hold true to ourselves and, I propose, that as person-centered therapists we can be of most help to our clients when we are able to hold true to ourselves.

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References

Alhimaidi, A. (2019). *The nature and effectiveness of therapies provided in counselling centres at the princess nourah bint abdulrahman university* [Unpublished PhD thesis]. University of Strathclyde.

Bobzien, C. (2022). *Measuring authenticity: Validation of the German Strathclyde Inventory (SI-22-G) using rasch analysis* [Unpublished Bachelor thesis]. Rheinische Fachhochschule Köln.

Bond, T. G., & Fox, C. M. (2015). *Applying the rasch model: Fundamental measurement in the human sciences*. Routledge.

Bozarth, J. D. (2001a). Congruence: A special way of being. In G. Wyatt (Ed.), *Congruence* (pp. 184–199). PCCS Books.

Bozarth, J. D. (2001b). Client-centered unconditional positive regard: A historical perspective. In J. D. Bozarth & P. Wilkins (Eds.), *Unconditional positive regard* (pp. 5–18). PCCS Books.

Cornelius-White, J. H. D. (2007). Congruence: An integrative five-dimensional model. *Person-Centred & Experiential Psychotherapies*, *6*(4), 229–239. https://doi.org/10.1080/14779757.2007.9688444

Du, E., Quayle, E., & Macleod, H. (2021). A qualitative study of patients' experiences and acceptance of computerised cognitive behavioural therapy in primary care, Scotland. *The Cognitive Behaviour Therapist*, *14*(24), 1–22. https://doi.org/10.1017/S1754470X21000210

Elliott, R. (2002). Hermeneutic single case efficacy design. *Psychotherapy Research*, *12*(1), 1–21. https://doi.org/10.1080/713869614

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69– 111). Pabst Science Publishers.

Elliott, R., Stephen, S., Cheng, L., Miller-Cole, K., Eyre, A., Riddell, E., & Hagman, V. (2016). *The personal questionnaire classification project: Developing a person-centered system to categorize client data-sets according to individualized statements of presenting problems* [Paper presented]. 12th PCE Conference, New York City, U.S.A.

Elliott, R., & Timulak, L. (2021). *Essentials of descriptive-interpretive qualitative research: A generic approach*. American Psychological Association.

Elliott, R., Wagner, J., Sales, C. M. D., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the personal questionnaire: A client-generated outcome measure. *Psychological Assessment*, *28*(3), 263–278. https://doi.org/10.1037/pas0000174

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy*. American Psychological Association.

Freire, E. S. (2007). *The Strathclyde Inventory: A psychotherapy outcome measure based on the person-centred theory of change* [Unpublished MSc dissertation]. University of Strathclyde.

Grafanaki, S. (2013). Experiencing congruence and incongruence. *Person-Centered & Experiential Psychotherapies*, *12*(3), 183–186. https://doi.org/10.1080/14779757.2013.839361

Haugh, S. (2001). A historical review of the development of the concept of congruence in person-centred theory. In G. Wyatt (Ed.), *Congruence* (pp. 1–17). PCCS Books.

Kaimaxi, D., & Lakioti, A. (2021). The development of congruence: A thematic analysis of person-centered counselors' perspectives. *Person-Centered & Experiential Psychotherapies*, *20*(3), 232–249. https://doi.org/10.1080/14779757.2021.1938179

Kirschenbaum, H. (2007). *The life and works of Carl Rogers*. PCCS Books Ltd.
Linacre, J. M. (2011). Practical rasch measurement – further topics. Tutorial 3. http://www.winsteps.com/a/winsteps-tutorial-further-3.pdf
Love, R. (2018). *Deterioration over the course of person-centred therapy: A hermeneutic single case efficacy design* [Unpublished MSc dissertation]. University of Strathclyde.
Mearns, D. (1997). *Person-centred counselling training*. Sage.
Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(2), 223–250. https://doi.org/10.1080/15298860309027
Neff, K. D., Long, P., Knox, M. C., Davidson, O., Kuchar, A., Costigan, A., Williamson, Z., Rohleder, N., Tóth-Király, I., & Breines, J. G. (2018). The forest and the trees: Examining the association of self-compassion and its positive and negative components with psychological functioning. *Self and Identity*, *17*(6), 627–645. https://doi.org/10.1080/15298868.2018.1436587
Neff, K. D., Whittaker, T. D., & Karl, A. (2017). Examining the factor structure of the self-compassion scale in four distinct populations: Is the use of a total scale score justified? *Journal of Personality Assessment*, *99*(6), 596–607. https://doi.org/10.1080/00223891.2016.1269334
O'Hara, M., & Leicester, G. (2018). *Dancing at the edge* (2nd ed.). Triarchy Press.
Ort, D., Moore, C., & Farber, B. A. (2022). Therapists' perspectives on positive regard. *Person-Centered & Experiential Psychotherapies*. https://doi.org/10.1080/14779757.2022.2104751
Owen, J., Adelson, J., Budge, S., Wampold, B., Kopta, M., Minami, T., & Miller, S. (2015). Trajectories of change in psychotherapy. *Journal of Clinical Psychology*, *71*(9), 817–827. https://doi.org/10.1002/jclp.22191
Pascual Leone, A. (2018). How clients "change emotion with emotion": A programme of research on emotional processing. *Psychotherapy Research*, *28*(2), 165–182. https://doi.org/10.1080/10503307.2017.1349350
Rogers, C. R. (1942). *Counselling and psychotherapy*. Houghton Mifflin.
Rogers, C. R. (1951). *Client-centered therapy*. Constable.
Rogers, C. R. (1957/1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, *60*(6), 827–832. https://doi.org/10.1037/0022-006X.60.6.827
Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science*, *volume 3*, *formulations of the person and the social context* (pp. 184–256). McGraw-Hill.
Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Constable.
Rogers, C. R. (1963). The concept of the fully functioning person. *Psychotherapy: Theory, Research & Practice*, *1*(1), 17–26. https://doi.org/10.1037/h0088567
Rogers, C. R. (1980). *A way of being*. Houghton Mifflin Company.
Speierer, G. -W. (2013). The differential incongruence model and its development. *Person-Centered & Experiential Psychotherapies*, *12*(3), 256–273. https://doi.org/10.1080/14779757.2013.839359
Stephen, S. (2016). *The Strathclyde Inventory: Next steps in the development of a person-centered outcome measure* [Paper presented]. 12th PCE Conference, New York City, U.S.A.
Stephen, S. (2020). *The Strathclyde Inventoryn as a measure of outcome in person-centred therapy* [Unpublished PhD thesis]. University of Strathclyde.
Stephen, S., Alhimaidi, A., & Zech, E. (2022). *Investigating the cross-cultural relevance of the Strathclyde Inventory: A pilot study* [Paper presented]. The BACP Research Conference, Dundee, UK.
Stephen, S., Bell, L., Kahn, M., Love, R., Mackintosh, H., Martin, M., Moran, R., Price, E., Whitehead, B., & Elliott, R. (2022). Comparing helpful and hindering processes in good and poor outcome cases: A qualitative metasynthesis of eight hermeneutic single case efficacy design studies. *Psychotherapy Research*, *32*(3), 389–403. https://doi.org/10.1080/10503307.2021.1934746
Stephen, S., & Elliott, R. (2022). The Strathclyde Inventory: Development of a brief instrument for assessing outcome in counseling according to Rogers' concept of the fully functioning person. *Measurement and Evaluation in Counseling and Development*, *55*(3), 187–206. https://doi.org/10.1080/07481756.2021.1955213
Von Glahn, J. (2018). Operationalizing the actualizing tendency. *Person-Centered & Experiential Psychotherapies*, *17*(1), 37–53. https://doi.org/10.1080/14779757.2017.1397050

Watson, N., Bryan, B. C., & Thrash, T. M. (2014). Change in self-discrepancy, anxiety, and depression in individual therapy. *Psychotherapy*, *51*(4), 525–534. https://doi.org/10.1037/a0035242

Wyatt, G. (Ed.). (2001). *Congruence*. PCCS Books.

Zech, E., Brison, C., Elliott, R., Rodgers, B., & Cornelius-White, J. H. D. (2018). Measuring Rogers' conception of personality development: Validation of the Strathclyde Inventory-French version. *Person-Centered & Experiential Psychotherapies*, *17*(2), 160–184. https://doi.org/10.1080/14779757.2018.1473788