Rogerian Style of Interpersonal Communication: Why is it not so Simple?

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Abstract: Carl Ransom Rogers was the only psychologist nominated for the Noble Prize. His whole professional life focused on major questions, such as, how to facilitate the process of interpersonal communication? What are the most important prerequisites of effective, aiming at mutual understanding, communication? Why people are so often unable to accurately communicate, even though they do not suffer from any form of speech and language pathology? According to Rogers, the crucial components of effective human to human contact are surprisingly simple in theory. Equally unexpected is that they are very difficult to implement into daily practice. Rogers's main concepts can be signaled by simple terms: non-directive approach, active person centered listening, transparency, congruency, unconditional positive regard, empathy and suspension of judgment. In the first part of our article, we review the Rogerian major frame of thinking and we add some comments on it. In the second section of our paper, we indicate selected obstacles disrupting practical use of his style of communication e.g. work overload and burnout, or disturbances caused by personality disorders.

Keywords: transparency, empathy, unconditional positive regard, active listening, burnout, personality disorder.

COULD IT BE SO SIMPLE?

Carl Ransom Rogers was exploring subtleties of human communication for decades. The number of books and articles written by this very prolific author is overwhelming. The amount of publications commenting on his life, work and achievements is even more overloading. When one looks at the essence, the conclusions reached after long term, rigorous scientific research done by Rogers, they appear surprisingly simple. They do not have to be explained with the use of fancy computer generated multi-dimensional models. They can be described in simple words, skipping almost any complicated specialized terms, which are absent in everyday vocabulary.

Could it be so simple? Is it possible that one may facilitate human to human communication in so many seemingly different contexts, without any advanced technology or tricky and spectacular techniques? Are there any universal injunctions opening the gate for constructive interpersonal encounters?

His main theoretical assumptions are nearly simplistic. As we were searching for the materials for this article, we listened to Rogers's lectures, and interviews available on the Internet[1]. Some of the records are very old. In spite of the poor quality of some of the soundtracks, it is very easy to follow – even for someone whose English is not their native language or for someone without a psychological background. His narration is characterized by clarity. Similarly, books and articles written by Rogers are, most of the time, easy reading.

If Rogers did find out what are the key components of facilitation of interpersonal communication, why do we face practical difficulties in this domain? Why do we hear so often complaints about teachers who do not listen to their pupils, professors who do not hear relevant messages sent by students or physicians who misunderstand their patients? Why do we so often struggle to understand each other, even when the speech is clear and the listener has no hearing problem at all?

In our article, we would like to share with the reader mainly two different issues. Firstly, the basics of the Rogerian approach; secondly, some considerations about obstacles jeopardizing its implementation. A reader with medical background may question our references to psychotherapy, which are repeated on many occasions. They may install a conviction that Rogerian principles are applicable in psychotherapy context only. However, we would like to emphasize that Rogers himself extrapolated his research findings onto a variety of communicational domains[2].

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[1]http://www.carlrogers.info/this_site.html (accessed November 12, 2013).

[2]Examples of such domains are, "education, religion, nursing, medicine, psychiatry, law, business, government, public health, law enforcement, race relations, social work" [2].

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The speech and language difficulties clearly belong here as well. Pathology of this kind requires specific therapy, and every engagement of speech and language therapist opens an opportunity for a psychotherapeutic alliance with the patient. It is virtually impossible to separate the speech and language therapy from psychotherapy. These two components are in close synchronicity[3].

There is not much research focused on the mentioned above issue. Robert J. Fourie is one of the few scientists who conducted an interesting study in the area of acquired communication and swallowing disorders with regard to therapeutic relationship [1]. Interestingly, Fourie's investigation indicates how humanistic-existential approach matches with a speech and language therapeutic engagement. Research project conducted by Fourie highlighted that

> how well a client adjusts to a communication disorder and is able to construct a personal meaning in response to the existential challenges of a communication disorder, may depend on the special relationship between a client and a speech and language therapist. … Arguments for the relevance of the Humanistic/Existentialist frameworks in the practice of speech and language therapy are particularly relevant for considering individuals with acquired disorders of communication; although they may also be pertinent to those with developmental or congenital conditions [1].

The citation accentuates the relevance of therapeutic alliance. Deeply existential, human to human encounter may take place only when such prerequisite is provided. Fourie's research clearly points out that if the specific relational qualities are present, patients/clients are able to detect and value them. Interviewed individuals commented on the value of being understood, being offered undivided attention as well as positive social gestures and warmth. Furthermore, Fourie claims that:

> Participants were aware of the components of a therapeutic relationship and valued these as essential to their own personal understanding of positive outcomes in speech and language therapy that highlighted specific qualities and actions of their speech and language therapist. Moreover, the participants gave coherent and plausible descriptions of their experiences in speech and language therapy that highlighted specific qualities and actions of their speech and language therapists [1].

Fourie pinpoints that it is very difficult to separate qualities from actions, these two issues are tightly interwoven.

SIMPLE PRINCIPLES – DIFFICULT IMPLEMENTATION. CRUCIAL THEORETICAL ASSUMPTIONS

Rogers's theoretical approach is described as non-directive or person centered. It means that whoever tries to be Rogerian has to allow the other person to be herself or himself as much as possible, has to avoid the temptation to impose his or her own way of thinking and feeling. The person who becomes a client, pupil, tutee, or patient is in the center of attention and he or she is his or her frame of reference, system of values, and constellation of unique emotions. On the contrary, in directive approaches most relevant is the trained professional who takes the responsibility, provides answers and directs for "he or she knows better". The listening is minimized and cognitively focused; once an expert gathered enough information, it is terminated. The center of evaluation is external, the decisions are made externally by the competent specialist. In everyday communication, directive and non-directive approaches tend to be mixed. The balance shifts, depending on the context and engaged individuals. Obviously, there are many situations when the directive approach is appropriate. If we investigate the medical context, there are situations when there is no time to be non-directive. Certain procedures have to be initialized immediately, and there is very little or no time to talk, listen, and sensitively detect affective states. However, if we remain in the domain of medicine, we can easily indicate that there are multiple occasions on which there is time and the conditions for the application of a non-directive approach, yet it is neglected in spite of the fact that such an approach is in the best interest of the patient.

[3]An interesting illustration of such interconnection could be a film titled "The King's Speech". This excellent production focuses not only on speech and language pathology and the therapy, but also on a unique relationship between two men. Deep, existential connection between them flourished, in spite of massive discrepancy in their social statuses. What makes the film even more interesting is the fact that screenplay is based on a true story [3].

To review the basic concepts, we will call directly on Rogers and quote him extensively as we think that there is no point in describing in our own words what is clearly stated by the author in question himself. After years of professional life as a counselor and psychotherapist, he stated that "[g]radually I have come to the conclusion that one learning which applies to all of these experiences is that it is the quality of the personal relationship which matters most" [4]. In psychotherapy, the safety of relationship creates an opportunity to gain insight and, as a result, to generate a mental change. In research work based on interviews, the ability to create a safe interaction is crucial. Without such an ability, the researcher will not access the information which is bound with shame or taboo. (The authors learnt about it recently, as we proceeded with the interviews focused on the experience of nudity). General public opinion tends to believe that in pharmacotherapy or any another form of sensu stricto medical intervention, the relationship seems peripheral. One may claim that relational qualities play a significant role in general practice, yet not in such medical domains as surgery or anesthetics. We usually do not talk much to anesthetists because our consciousness is soon switched off by chemical substances. But at this same time, even a brief contact with a physician responsible for anesthesia may significantly lower pre-operative anxiety.

In all papers written by Rogers, certain attitudinal ingredients are listed as crucial in any helping relationships. He indicates congruency (or synonymic realness and transparency) as one of the essential attitudinal components. According to Rogers, someone is congruent when he or she, "is what he is, when in the relationship with his client[4] he is genuine and without 'front' or façade, openly being the feelings and attitudes which at the moment are flowing in him" [4]. Congruence means "that the feelings the counselor (teacher, doctor, social worker) is experiencing are available to him, available to his awareness, that he is able to live these feelings, be them in the relationship, and able to communicate them if appropriate. It means that he comes into a direct personal encounter with his client, meeting him on person-to-person basis. It means that he is being himself, not denying himself" [4]. Incongruence is the opposition of congruence. In his book *Person to person*, the author claims that "We could each of us name a person whom we know who always seem to be operating from behind a front, who are playing the role, who tend to say things they do not feel. They are exhibiting incongruence" [4].

Congruence is seen by Rogers as the main factor in psychotherapy which may lead to a change of personality. One may raise a question whether being congruent serves any purpose beyond a highly specific therapeutic setting. It is a complex issue. It seems that the whole process of socialization is to the great extent focused on reconstructing of primal congruence. Newborn appears as primarily congruent; it smiles when it feels like smiling, cries when there is a reason to cry, spits out if something does not taste good. Much earlier than it begins to speak, it learns to signal to other people what is wanted and what is not. When a child is picked up, it can firmly inform an adult that it wants to get back on feet. It can twist in a second so effectively that a holder may be frightened so as not to drop it. As they begin to speak, they talk honestly, they do not hesitate, they simply convert thoughts and feelings into words. There is no façade at all: the child is totally transparent and genuine. But inevitably, it has to unlearn such a way of being, at least in the presence of others. As we grow older, transparency has to be replaced by a variety of camouflages, masks and disguising tricks. Transparency appears to be a luxury – it is a freedom which has to be sacrificed on the altar of conformity and social adaptation. We have to restrain our feelings and desires, hide them. We have to quickly learn that we cannot simply get angry and throw the toys all over the place. There is no other choice but to suppress negative, socially intolerable feelings. Without being incongruent, we could not survive in the social arena. Simultaneously, we wish to be congruent. It is the beauty of intimacy, closeness, informal and private relationships that we can be congruent or at least more congruent than within the public domains. Do we expect from a priest, professor, physician or any other human fellow to be congruent? It is a very tricky question. On the one hand, we expect them to behave in a specific way which fits into a prototypical social role of priest, physician etc. We do not want a priest to be cheerful during a funeral, even if it would mean perfect authenticity. We do not care if he

[4]Rogers decided to use the term "client" instead of "patient". In his opinion, the second term implicates very specific, medical connotations. In everyday language, "patient" signals that somebody is sick and needs to be diagnosed, treated and taken care of by competent expert placed in position of knowledge and power. The client does not have to be sick and does not require diagnosis. In Rogers's view, diagnosis is a secondary issue in helping people with mental difficulties. He often indicated that the forceful attempts to diagnose are very disruptive to the process of psychotherapy.
Jeffrey Masson commented on these issues in such words, "it is unarguable that Rogers did away with some of the 'trappings' of the imbalance in the power relationship. He insisted on hanging the designation 'patient' to 'client', which, being more mercenary, is closer to the truth" [2].

feels joy because a deceased person suffered for years and arrival of death meant release from the horror of living. He is expected to behave appropriately for such a ritual, in a restrained and sad manner. Are priests and physicians allowed to express dislike or strong liking of anyone? They may truly feel this way as every human does. Rogers deals with these difficult questions in a simple way. He claims that we should be able to live our feelings, be them in the relationship and communicate them…when appropriate. Unfortunately, the definition of appropriateness is not always explicit, unambiguous.

Being congruent may result in controversial behavior. It may lead directly to the edge separating appropriate from inappropriate. One of the Rogers's collaborators, Eugene T. Gendlin commented on congruency in such words, "[a]lso 'congruence' for the therapist means that he need not always appear in a good light, always understanding, wise, or strong. I find that, on occasion, I can be quite visibly stupid, have done the wrong thing, made a fool of myself. I can let these sides of me be visible when they occurred in the interaction" [4]. He wrote it in the context of work with schizophrenics, yet in his opinion it is applicable in other relationships as well. What could be so controversial in such expression of congruency? At least two things could be taken into consideration. Some people do not allow a psychotherapist, speech therapist or physician to make a fool of himself. Definitions of their social roles do not include visibly stupid behavior. They are expected to be strong and wise. The moment some people witness such behaviors, a negative reaction may be triggered. If such a scenario occurs, congruency – which is supposed to facilitate human to human encounter – could effectively sabotage it. The second issue is that it is relatively easy to be transparent when one experiences positive (at least in social evaluation) states of mind and affect. Yet if it is something negative or threatening, most of us automatically try to hide it away. Certainly, there are people among us who are unable to laugh in reaction to their own foolish behavior. They are very defensive when something like that comes close to the "interpersonal surface". Many of them are therapists and physicians who desperately try to protect the image of serious, competent, and infallible expert.

As the next crucial communicational component, Rogers indicates empathy. This term is very popular, the vocabulary of almost each one of us contains this word. However, a closer examination reveals that we do not always understand the proper meaning conveyed in this word. Rogers claims that "[t]o sense the client's inner world of private personal meanings as if it were your own, but without ever losing the 'as if' quality, this is empathy" [4]. He is aware how uncommon is an empathic state of being with another person. Rogers suspects that "each of us has discovered that this kind of understanding is extremely rare. We neither receive it nor offer it with any great frequency. Instead we offer another type of understanding which is very different, such as 'I understand what is wrong with you' or 'I understand what makes you act that way'. These are the types of understanding which we usually offer and receive – an evaluative understanding from the outside" [4].

Anyone who has ever tried to be empathic in conversation with another person knows how difficult it is. One may not want to get tainted with emotional states of another person. It applies especially to negative feelings. We often want to protect ourselves from being infected by somebody's despondency, despair or deep depression. We are tempted to turn for some kind of instant intervention that would modify such emotional state or simply to get out of such interaction, to escape it. In state of empathizing, one deliberately allows oneself to get exposed to and contaminated with somebody else's emotions. At times, we are keen to connect with another person's feelings, providing they are positive. As an antidote for feeling down, we may accept an invitation to a party assuming that our low mood will change in the presence of cheerful others. But why should we allow others to drag us down into dark oblivion of despair? It may look like a masochistic tendency. There are more risks in empathy than just bad mood. For empathic understanding, the ability to perceive the world from the perspective of another person is essential[5]. It is relatively easy in the case of someone similar to us, but it is incredibly difficult with somebody who is very different. Usually, we automatically perceive the surroundings in the way

[5]The ability to empathize is crucial not only for psychotherapist or speech therapist. Research indicates that a relational quality is significant in a variety of supportive relationships, including the one occurring between doctor and patient. In an article addressing the issue of patient-physician communication, John M. Travaline, Robert Ruchinskas and Gilbert E. D'Alonzo states that "empathy is a basic skill physicians should develop to help them recognize the indirectly expressed emotions of their patients. Once recognized, these emotions needs to be acknowledged and further explored during the patient – physician encounter. Further, physicians should not ignore or minimize patient feelings with a redirected line of enquiry relentlessly focused on „real" symptoms. Patient satisfaction is likely to be enhanced by physicians who acknowledge patients' expressed emotions. Physicians who do this are less likely to be viewed as uncaring by their patients" [5]. The quote indicates the relevance of the recognition of emotional aspect of empathy. One has to remember that there are more relevant components contributing to empathy.

that fits well with our personal interpretational scripts. This is the way we make sense of what we experience. It is very difficult to give up personal views, systems of values, sexual preferences, likes and dislikes and to temporarily try to be somebody else. It requires, to some extent, to be able to dissociate from oneself or at least to loosen the usual association.

Rogers believed that positive regard is another important component of supportive, caring and growth-promoting relationships. Positive regard occurs when one is capable of

> warm, positive, acceptant attitude toward what is in the client. It means that he prizes the client, as a person, with somewhat this same quality of feeling that the parent feels for his child, prizing him as a person regardless of his particular behavior at the moment. It means that he cares for the client in a non-possessive way. (…) It involves an open willingness for the client to be whatever feelings are real in him at the moment – hostility or tenderness, rebellion or submissiveness, assurance or self-depreciation [4].

Going further, we have to mention specific form of positive regard which is (according to Rogers himself) questionable to some extent[6]. It is called unconditional positive regard. How should we understand this notion? Rogers says that "by this I mean that the counselor prizes the client in a total, rather than a conditional way. He does not accept certain feelings in the client and disapprove others. He feels unconditional positive regard for this person. This is an outgoing positive feeling without reservations and without evaluations. It means not making judgments" [4].

Rogers indicates that unconditional positive regard may be experienced by children who are lucky to have parents offering such a quality. They have the opportunity to soak up the unconditional love and acceptance and then they may in return give it to other people in adulthood. Such unconditionality is sufficiently present in 'good enough' parenting. On the other side of continuum which begins with total unconditional positive regard, we see the conditional positive regard. This is (if we remain within the domain of upbringing) a style of parenting that is quite often practiced. The child receives positive regard under such circumstances, yet only as long as she or he fulfills certain conditions. Such parents love their offspring and offer all kinds of support, providing that their children live up to specific expectations. Punishment in conditional parenting does not have to take a form of physical disciplining, it can simply take a form of emotional withdrawal or another subtle manipulation. Being judgmental appears interconnected with conditional positive regard. At first one is judged, evaluated, then, as a next step, comes acceptance or rejection.

We are constantly evaluated. Educational systems are based on ongoing evaluation. We are also under constant scrutiny in the professional environment. Academic jobs are classic examples of never absent evaluation. One of the significant dimensions of academic functioning is publishing. There is a popular saying illustrating this requirement – "You will publish or you will perish". This is just one of many examples of endless evaluations which we are going through. Rogers indicates that within the therapeutic relationship we should rather try to suspend the judgment – become non-judgmental. Judgments certainly can sabotage the whole therapeutic process. It appears relevant to add at this point that the reception of judgment depends on contextual subtleties. It is obvious that people differ in the way they evaluate others. Someone may assess our behavior and communicate it directly, yet it does not evoke a defensive reaction. It does not have to make us angry, frustrated, annoyed, or despondent. On the contrary, we can follow the evaluation as useful means for further open-minded exploration. Yet in some cases, it is enough to spot a facial micro-expression, which conveys infuriating message. Such a judgment may contain disdain triggering highly defensive responses. In a similar way we often respond to an evaluation which is imposed on us. If we are pressed to oblige, we

[6]Jeffrey Masson indicates how easily one may doubt whether unconditionality could be present in therapeutic relationships. He wrote that "the unconditional positive regard that Rogers wants the therapist to feel is something that cannot be legislated into existence any more than can love. We cannot feel these emotions upon command: either they are present or they are not. And the mere fact that somebody has come to you in need does not in and of itself mean that you will love the person. 'Unconditional regard' is not something that seems either likely or desirable. Faced with brutal rapist who murders children, why should any therapist have unconditional regards for him?" [2] It seems that unconditional positive regard could be matched with the notions of Agape. In spite of a long history of Christian propagation of such attitude toward human fellow, it remained a rare attitudinal quality. However, it does not negate the fact that there are individuals who are capable of Agape, unconditional love for other human beings. Some of them reached beatification.

are keen to disobey. The effect of reactance can be extremely potent in some cases[7].

The described above approach is not a panacea. It has limitations and shortcomings[8]. Rogers himself was aware of them. He claimed that "I have learned, especially in working with more disturbed persons[9], that empathy can be perceived as lack of involvement, that an unconditional regard on my part can be perceived as indifference; that warmth can be perceived as a threatening closeness, that the real feeling of mine can be perceived as false". Then he continues that "I would like to behave in ways, and communicate in ways which have clarity for this specific person, so that what I am experiencing in relationship to him would be perceived unambiguously by him. Like the other conditions I have proposed, the principle is easy to grasp; the achievement of it is difficult and complex" [4].

Let us mention another limitation, which appears relevant to us. Rogers, especially in his later years, got involved internationally in cross-cultural encounters. He traveled and he spoke with people living in various countries[10] and belonging to different races and religions. He believed that his style of communication could lead to resolution of international conflicts and could make the world a better place to live in. He assumed that even such extremely total institutions as the army could implement humanistic, person oriented interpersonal principles.

It seems that there is a little chance for being Rogerian in a macro-scale and applying his principles in such fields as e.g. international politics or an army. Yet we are convinced that in micro-scale, in family life, intimate relationships, between therapist and client[11], physician and the patient, Rogerian principles are indispensable.

WHY IS IT SO DIFFICULT?

Why is it so difficult to implement the principles presented above? Why do we not offer empathy and congruence to the other human being in everyday interaction? Why do we not often receive warmth and understanding from the others?[12] There may be a number of reasons for such a state of affairs. They may arise from the manner in which the whole systems that we belong to are organized. Let us consider some of them, e.g. the medical care. Those indicated by us are related to the Polish healthcare system. We have to remember about this limitation, if we want to avoid an error of generalization. All we wish to achieve is to draw some attention to few often ignored factors; one could call them "soft" or, in other words, qualitative observations. Even if a specific healthcare system work is satisfactory "in numbers" (a quantitative perspective), it may fail in the patients' opinion (qualitative perspective; such an evaluation matters, even if it is highly subjective).

Overload and Burnout

What often shapes those evaluations is the manner in which the patients are approached. In numerous hospitals, clinics and ambulatories, basic ethical rules are ignored. In significant numbers of cases, patients are treated arrogantly, in patronizing or humiliating way. Sometimes they are approached more elegantly, but, at the same time, they are drastically under-informed or misinformed. One of the biggest problems of Polish medical care is the failure in providing patients with proper information. It seems so simple that one might argue that it is not worth talking about. Paradoxically, what appears strikingly simple is practically impossible to implement. Almost everyone who was in need of medical help could provide

[7]"Psychological reactance is an aversive affective reaction in responses to regulations or impositions that impinge on freedom and autonomy. (…) This reaction is especially common when individuals feel obliged to adopt a particular opinion or engage in a specific behavior" [6].

[8]Some of the shortcomings are indicated by Jeffrey Masson. According to this author, if we examine crucial conditions indicated by Carl Rogers, "we realize that they appear to be genuine only because the circumstances of therapy are artificial. … In fact the therapist is not a real persona with the client, for if he were, he would have this same reactions he would have with people in his real life, which certainly do not include 'unconditional acceptance', lack of judging, or real empathic understanding. … If he appears to be all-accepting and all-understanding, this is merely artifice; it is not reality. I am not saying that such an attitude might not be perceived as helpful by client, but let us realize that the attitude is no more that playacting. It is the very opposite of what Rogers claims to be the central element in the therapy: genuineness" [2]. Jeffrey Masson is in general very skeptical about usefulness of psychotherapy.

[9]He wrote: "I am also aware of the possibility that different kinds of helping relationships may be effective with different kinds of people. Some of our therapists working with schizophrenics are effective when they appear to be highly conditional, when they do *not* accept some of the bizarre behavior of the psychotic. This can be interpreted in two ways. Perhaps a conditional set is more helpful with these individuals. Or perhaps – and this seems to me to fit the facts better – these psychotic individuals perceive a conditional attitude as meaning that the therapist *really* cares, where an unconditional attitude may be interpreted as a apathetic noncaring. In any event, I do want to make it clear that what I have given are beginning formulations which surely will be modified and corrected from further learning" [4].

[10]Rogers also visited Europe.

[11]As a psychotherapist, I worked with a diversity of clients, including schizophrenics. My personal experience made me rather skeptical in terms of psychotherapeutic success in work with this specific category.

[12]An extensive body of socio-psychological literature exploring the possible answers to these questions is available. For example, Mark H. Davis investigated the complexity and limitations of empathy [7]. Mark Leary described how often we tend to sacrifice congruence on the altar of self-presentation [8]. Stanley Milgram conducted a classical experiments on obedience to authority which proved that under specific set of circumstances we can effectively suppress our warmth and switch off understanding [9].

illustrations for such a claim. The patients feel lost in the labyrinths of hospital corridors and meanders of procedures. They are sitting in waiting rooms without knowing for how long they have to stay there. They are going for a treatment without knowing what is going to happen, how long it would take and what outcomes are possible. They are often marginalized in decisional processes, or even deprived of the possibility to decide for themselves. Psychological assistance is seldom suggested or available. Psychologically sophisticated, elegant, caring, and highly ethical medical care exists mainly in the virtual reality of Polish TV series[13]. Generally speaking, the communication between staff and patients fails very often, in spite of the fact that it has been emphasised in scientific literature for many years [10]. Many professionals from the medical field assume that the communication between staff members is obvious, but a patient does not have to be informed. Some of them represent the point of view that it is in the best interest of the patient not to be told what is happening or what is going to happen. The patients remain beyond the circulation of even basic information. There is often no time for explanation or counseling. The need to rush leads to doing only what has to be done for physical safety of the suffering person; anything else is a luxury that the system cannot afford. Mental well-being of the patient is pushed into the background.

Exhaustion or professional burnout[14] appears to be another paramount factor lowering the quality of Polish health care. It is a practice known for decades that every day a nurse, physician or physiotherapist has to manage dozens of patients. They are chronically overloaded with cases. The state of overwork is so common that it appears as normal. It is simply accepted seen as obvious that a physician has to finish night duty and work on the next day, without any break. Nobody cares how tired she or he is, and how dangerous could be the errors committed under such circumstances. It seems that work-time limits respected by other professions (drivers, airplane pilots etc.) are ignored in the domain of medicine. Polish physicians often work in the way that ignores common sense and breaks the law[15]. Medical staff are not informed or guided through the domain of psychological problems such as burnout and its prophylactic, even though they are heavily exploited [11]. Workers struggle with the burnout symptoms or fully developed syndromes for years. At times, the physician who is asked to see the patient again reacts with irritation, fury, and aggression. Such reactions may be catalyzed by burnout[16]. Fengler follows Kemper and lists the typical symptoms of this disorder [11]. The overloaded, burned out physician functions in a "survival mode". Functioning in such mental states makes it nearly impossible to pay attention to such issues as informing the patient and counselling, not to mention the relational subtleties involved in psychotherapeutic interventions. After all, it is a truism to state that actions of physicians, nurses or physiotherapists often require psychotherapeutic skills. The nature of their work spontaneously creates circumstances for therapeutic engagement; it requires an effort to step out of it, to disengage. It is difficult to expect from an overworked, suffused with sense of nonsense of professional routines, irritated doctor that he or she would be genuinely interested in and could take care of emotional states of the patients. In the context of chronic overload of cases – endless flow of tiring interpersonal interactions – avoidance of any further close encounters and hiding behind tools, machines and routine procedures of examination and treatment seem to be the best protection against devastating emotional drainage. Paradoxically, the modern medic can make use of the constantly growing numbers of tools and pieces of equipment which are giving a chance to hide from the patients, especially patients' fears, despairs and neediness for human to human contact. Surprisingly, an impressively performed operation, a complicated procedure carried out with the use of fancy equipment is often easier than a close encounter with a person in the state of mental tension, turmoil, or, psychologically speaking, state of

[13]As an example, we could indicate Polish TV serial titled "Lekarze" (trans. "Medics"). In this popular production, almost everything is "nice". Besides interiors of the hospital, actors are good looking, actresses pretty, patients nicely treated. In almost every interaction, viewers see a lot of tenderness, loving care. Polish TV series is a cliché of "Western" productions.

[14]We understand burnout as a physical and psychological state of depletion caused by long term negative emotional states correlated with work environment [11].

[15]There is an article published recently in the Polish newspaper "Rzeczpospolita", which addressed the issues voiced in this article. According to "Rzeczpospolita", physicians are overtired but still have to diagnose and operate on patients. Recent research conducted in 119 hospitals revealed that in 35% the law regulating working hours was disobeyed. In some cases, medics remained on duty continuously for 48, 72, 96 or even 103 hours. In accordance to labour law, medical stuff can work 48 hours per week, including night duty at the hospital. Staff member may sign a special clause and raise the limit up to 67 hours per week. However, according to the European Union directive, a medical staff member must have an 11 hours of undisturbed break every 24 hours and 24 hours of uninterrupted break every week [12].

[16]Fengler [11], following Kaslowen and Schuman, lists symptoms of burnout such as: 1. Reluctance related to going to work. 2. Ongoing complaints about the lack of willingness to work or feeling of overwork. 3. The sense of isolations from the world. 4. The perception of life as tiring and gloomy. 5. Increasing number of negative transferences during interactions with clients. 6. Irritability, oversensitivity and lack of patience in home environment. 7. Cases of falling sick without visible causes. 8. Thoughts about escape or suicide.

decompensation. Active, supportive listening is in such context very exhausting. If listening takes place, it typically has a cognitive and evaluative, non-empathic character. This type of listening is focused on the search for information, facts and critical analysis of collected data. If one wishes to offer someone support, one must be able to activate the modality of empathic listening [13].

The tendencies described earlier are perpetuated by the low level of theoretical knowledge and practical psychological skills of medical staff. In programs of medical studies, subjects such as psychology, psychotherapy – various aspects of interpersonal communication – remain peripheral or do not exist. Students and staff are not familiar with basic psychopathological categories and that often directly influences their contacts with patients. It is not unusual to witness negligence or ignorance in the domain of basic components of interaction. The authors themselves, on multiple occasions, have experienced encounters that were breaking the rules of eye contact, obligatory in our culture[17]. Fundamental therapeutic techniques like empathic listening, paraphrasing, feedback information, proper questioning and accurate understanding, acceptance of ambivalent affect, and understandable explanation are seldom practiced or unknown. Repeated attempts to organize workshops assisting in acquiring such competencies are not welcomed by medical staff members. There are no doubts about attending pharmacology courses, but psychological sensitisation workshops seem pointless. Additionally, as mentioned earlier, the eventually acquired psychological skill may add to overload. What is not perceived and recognized cannot bother, absorb attention and drain energy.

Personality Disorders

Another component with potent influence on the manner of communication is a style of character. Personality disturbances certainly result in communicational difficulties. Highly specific, persistent communicational trends are core components of personality disorders. If a clinician screens a specific person in view of disturbed personality, the conversation and other components of interpersonal communication (e.g. non-verbal level) are the main sources of diagnostic information. Clinician's personality is her or his crucial therapeutic tool. What is the most important for a dentist are his manual skills, for a musician his sound sensitivity, for psychotherapist his personality and insightfulness.

Each one of us can be described as a constellation of traits and qualities, which are to some degree distinctive or that are unique in terms of specific proportions and combinations of available features. It is very difficult to change the structure of character. Some modifications appear possible. Changes come with aging, some of as try to work hard on personality, try to impose self-discipline and fight against certain traits. One may be skeptical about the durability of any attempted radical changes. In the case of very insightful individuals, some adjustments or "fine tuning", appear possible.

There are specific clinical classifications focused on pathological personality types. For example, the formal psychiatric nosology listed eleven personality disorders. Before we develop the issue, it is worth asking when do we stop to talk about style of character and when do we begin to discuss a personality disorder? We could say briefly that according to the diagnostic manual of mental diseases, an individual with disturbed personality "show[s] deeply ingrained, inflexible, and maladaptive patterns of relating to and perceiving both the environment and themselves" [14]. Most disturbed personalities may cause relational havoc. Nearly all extremely destructive individuals in human history could be diagnosed with character aberration. Clinicians practicing psychotherapy know how difficult it is to work with such people and how risky are their therapeutic engagements. We all came across people who are very difficult to work with or to be with, especially in closer, more intimate relationships. In such cases, there is very often a specific personality component which is, to a great extent, responsible for these troubles.

Earlier in this text we indicated a few obstacles affecting the Rogerian style of communication. At this moment, we would like to add one more, "disturbed personality". In general, we could say once again that every pathological character equals disturbances in intrapersonal and interpersonal communication. The variability is quite striking. In the case of schizoid, one can observe and experience (when interacting), a "restricted range of emotional experience and

[17]On multiple occasions, we experienced situations involving interactions with physicians, without the introduction of eye contact. I remember clearly a contact with a physician who during the diagnostic interview looked exclusively on the screen of computer. I watched him carefully, as the situation triggered my curiosity. This specific physician had mastered this kind of interaction to perfection. He managed to go through the full interview (prior to my discharge from the hospital) without a single eye contact with me.

expression" [14]. Such persons are often described as "aloof and cold". They "rarely reciprocate gestures or facial expression" [14]. Somebody enveloped in schizoid personality could be described as extremely introverted, socially withdrawn and lonely. Their 'interpersonal temperature' is very low. They represent the opposite of what Rogers named "relational warmth". For someone equipped with strong schizoid features, it is impossible to be perceived as a warm provider of tender, loving care. Such an individual could become a very good lighthouse keepers, distinguished solo sailors or astronauts, providing that they could be the only occupants of the cosmic capsule. As an antithesis of schizoid, we could indicate histrionic personality disorder "characterized by colorful, dramatic, extroverted behavior" [14]. Practically all actions, especially during public appearance, are in such cases driven by attention seeking. They behave seductively (inappropriately to situation), tend to exaggerate emotional expressions and present with a style of speech which is also excessively impressionistic and lacking in detail at the same time. Paradoxically, in spite of overt emotionality, histrionics may not be aware of their real feelings. Does histrionic personality predispose somebody to display Rogerian style of communication? Probably not. Rogers does not talk about seduction as a core of any interaction. He talks a lot about intense attention, but not attention seeking. He emphasizes appropriate emotional expression, not shallow and exaggerated sentimentality. He talks about person centered approach, but in the case of the above named personality, what usually happens tends to be a histrionic person centered situation.

We would like to focus and examine the specific personality syndrome named narcissism. It is often correlated with high achievements. The more narcissistic someone is, the more energy he or she may activate to achieve success and high social status. In our present culture, physicians belong to professional groups of high esteem and often relatively high income. It is not surprising that we can often come across highly narcissistic individuals in the group of medics. What is typical for this condition, metaphorically presented in mythology? If we look at the diagnostic criteria for narcissistic personality disorder, we come across such notions as pervasive pattern of grandiosity, lack of empathy, interpersonal exploitation, sense of entitlement, need for constant attention and admiration and feelings of envy [14]. Some theoretical approaches assume that we all begin our existence submerged totally in "narcissistic protoplasm". In intrauterine life or as newborns, we seem unable to de-center from our initialized self. Other people who are taking care of an infant are expected to be available at any moment and provide instant gratification to all needs. If this is not the case, furious reactions are expressed. Under favorable circumstances, the baby really fills the center of a small relational world. It needs time to realize that there are other people, living separate lives and following their own life paths. It has to learn that people around have their own feelings and thoughts. We have to learn how to grow out of "narcissistic protoplasm". However, some of us remain narcissistic throughout life. It is often very difficult to estimate our degree of narcissistic predispositions. Narcissistic traits significantly, however with various intensity, influence at least a few personality disorders. According to Alexander Lowen [15], if we arrange a continuum of narcissism, it should begin with phallic narcissistic character. As the narcissist component becomes more influential, we could talk about narcissistic character, then borderline, psychopathic and paranoid personality. As one looks from Lowen's perspective, it is evident that narcissistic tendencies are interwoven with the group of styles of character.

How does the narcissistic personality fit with Rogerian style of interpersonal communication? The shortest answer would be – poorly – "like a bull and carriage". There are many reasons for such a statement. For example, Lowen argues that "the more narcissistic one is, the less one is identified with one's feelings" [15]. The ability to connect with one's real emotions is a crucial element of being congruent. A person cannot be real without access to her or his true feelings. Without access to the flow of genuine emotions, the state of falsification is always present. There is no possibility to remove the façade as there is nothing, easily accessible, behind it. The real emotions (in severe cases) are disconnected and they do not match the image projected on social environment. The image is the primary preoccupation of a narcissist. Lowen elaborated on those issues and wrote that:

> We both feel and think. Our dual identity rests on our ability to form a self-image and on our awareness of the bodily-self. In a healthy person, the two identities are congruent. The image fits the body reality as glove fits its owner's hand. A personality disturbance occurs when there is lack of congruence between the self-

> image and the self (true self). The severity of this disturbance is in direct proportion to the degree of congruence. The discrepancy is most marked in schizophrenia, where the image bears almost no relationship to reality. Mental institutions contain many people who see themselves as Jesus Christ, Napoleon or some other renowned figure. Since this image conflicts sharply with the bodily reality, the result is confusion [15].

Obviously, not all narcissists are confused schizophrenics. Some of them are very well adjusted professionals, politicians and religious leaders or paradoxically highly estimated, charismatic, psychotherapists running lucrative private practices and motivational trainings. However, if we evaluate them from a Rogerian perspective, they are unable to establish relationships based on a high degree of congruence. They are, by definition, incongruent to some extent all the time. In closer, more intimate encounters, it may become a frustrating obstacle. Of course, it is not always the case. There are people who are impressed with narcissism. In fact, it is quite difficult not to be charmed or seduced in our contact with a skilled, hidden in attractive 'interpersonal envelope', narcissus. In some cases, the ability to sustain a great façade is amazing.

What about an empathy? According to Rogers, a truly caring, supportive, growth-promoting relationship is not possible without empathy. This makes empathy a crucial relational component. Let us refer to Lowen again, as he described this issue accurately. Lowen claims that:

> Denial of the feeling characteristic of all narcissists is most manifest in their behavior toward others. They can be ruthless, exploitative, sadistic, or destructive to another person because they are insensitive to the other's suffering or feeling. This insensitivity derives from a insensitivity to one's own feelings. Empathy, the ability to sense other people's moods or feelings, is a function of resonance. We can feel another person's sadness because it makes us sad; we can share another's joy because it evokes good feelings in us. But if we are incapable of feeling sadness or joy, we cannot respond to these feelings in another person, and we may even doubt that they have such feelings. When we deny our feelings, we deny that others feel [15].

Narcissists, "fail to see others as real people; in their eyes, others exist only as objects to be used"[18] [15]. They are preoccupied with power and control. They desire to be in charge and to impose their own wishes, values and judgments on the others. It means that they are strongly predisposed to be directive and judgmental; shortly speaking, they are anti-Rogerian.

What do the social systems do to protect patients from exploitative, narcissistic physicians or what do they do to shield the clients against charming, psychopathic psychotherapists? The shortest answer is "nothing". The narcissistic characters are often prized. They are usually ambitious, highly achieving, perfectionistic professionals. The image they manage to project on the others is stunning. If we take into consideration selection procedures, in fields like medicine or psychology, we quickly realize that they are based primarily on academic achievement, not on personality assessment. Especially in the case of future psychotherapists, selection criteria focused purely on academic issues, seem disastrous. The personality is (at least, according to Rogers) the crucial tool for psychotherapeutic work. If this tool is damaged, it can also cause damage.

CONCLUSIONS

The Rogerian concept of therapeutic communication has been known for decades. It crystallized as a result of professional experience, already in the first half of the twentieth century. After WW II, in Chicago, Rogers worked on various research projects aiming at verification and explanation of his assumptions. In the second half of the century, he published many articles and books which explained in detail the humanistic, existential, non-directive, person centered approach, and discussed key issues of effective communication in professional relations focused on helping another human being. At first glance, it appears that one deals with commonly known and simple rules constituting interpersonal relations.

[18]This feature became apparent in a conversation which my female colleague had with an executive officer of provincial health care. This man seemed to be a highly narcissistic individual. After a few glasses of wine, he confessed that all his life he acts like a chess player. Next move is carefully calculated. Other people are perceived as chess figures. If the winning strategy requires it, they are simply removed and there are no feelings attached to such action.

The multilevel difficulties begin to transpire as the attempts of implementations in various domains are made. Each of the co-authors is aware of it, as they tried to apply those rules in their own way in different contexts –in the area of medically applied psychology as psychotherapist, and as researcher collecting qualitative data *via* interviews concerned with sensitive, often embarrassing issues. These are the situations when one begins to be aware how complex competences are required, how extensive experience is needed, and also how powerful the schemes of perceptions and expectations are. These moments make us realize how relevant the traits of character or features of social systems are in which we are involved. These are the moments when one searches for answers why something looking simple and easy is not as it seems. Then we begin to analyze, more or less systematically, factors and skills contributing to attentive listening, congruency, empathy or unconditional regard.

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