Blue Suede Shoes: The Therapist's Presence

Michelle Webster

Therapy that prioritises feelings focuses on the development and maintenance of emotional relationships. I want to reflect on how the therapist's emotional involvement is developed and maintained in therapy that focuses on feelings.

But don't you step on my Blue Suede Shoes,
You can do anything,
but lay off of my Blue Suede Shoes

Therapists' 'shoes' are their feelings, styles of relating, personal and professional values, approaches to therapy, methods of working and ways of being with clients. How therapists wear their 'shoes' can either help or hinder the development and maintenance of therapeutic relationships. By exploring the features of therapists' 'shoes', we can discover what therapists need in order not to tread on their clients' 'Blue Suede Shoes'. In order to consider the nature of the therapist's emotional involvement, which I think is an awesome task, I will use the metaphor of shoes for both therapist and client.

Well, that's my introduction. I had planned to complete it one Sunday afternoon. But when I sat down I felt anxious, jittery. I had nothing in front of me to help me say what I wanted to say. I set off to Gleebooks. I found what I wanted and went home armed with books on the history of shoes (Swann, 1982), a reader on Carl Rogers (1990) and a book called *The* Problern of Being Human *(1967).*

I couldn't finish the introduction that Sunday afternoon. It was crazy of me to think I could write a 300 word introduction in three hours. I completed the first paragraph on Sunday. I had a regular working week ahead of me. I was not going to let this introduction beat me. I remembered a supervisor once advising me that when I was writing I should touch the work each day to keep it with me so that it was warm to my mind. I did just that. Each night I spent an hour on the introduction.

Have to get a move on here. I have read that introduction again. I definitely need to focus on the phrase 'emotional involvement in therapy'. I definitely need to get on with this task.

My stomach tightens again. Slow down. Breathe. Take stock, find the focus, here goes ...

Emotional Involvement

Emotional involvement means just that. Can you recall your relationships with partners, friends and family? 'Heaven forbid,' some of you might say, 'don't get me feeling about myself.

Although clients describe problems in terms of what other people or they themselves are *doing,* it seems to me that they come to therapy because of their *feelings*

I am supposed to be thinking about my clients' feelings.' But to understand emotional involvements in therapy, we need to consider our own emotional involvements. In personal relationships, we are involved at a feeling level. We bring to relationships our felt experiences of ourselves and others. Let us consider our first emotional involvement in life, with Mum.

There, I knew I could get this paragraph in somewhere.

This caregiver had the task of nurturing and protecting a small and totally dependent being. As babies we responded to basic needs to be held, soothed and pleasured. The crucial word is 'responded'. As we responded to these needs, our mothers responded to us. Winnicott spoke clearly of the mother's role:

> 'Can we not say that the mother adapts herself to what the baby can understand, actively adapts to needs? This active adaptation is just what is essential for the infant's emotional growth and the mother adapts herself to the baby's needs'
> (Winnicott, 1964: 87).

Infants respond to how the mother touches and holds them and to whether it is done through love or duty. They respond to nonverbal expressions, such as the nurturer's facial expressions and vocal intonations. Infants intuit. They feel the extent of the caring and respond accordingly. The mother's behaviour makes the infant feel either warm, safe and secure or cold, scared and threatened. This is emotional involvement, not necessarily healthy or beneficial for the child, but emotional involvement.

When infants feel warm and safe, they look, gurgle and smile at their nurturer. When they feel cold, scared and threatened, they become agitated and easily upset. Some withdraw and become silent, as if invisible. How babies are cared for in an emotional way establishes their sense of themselves and their expectations about being responded to within relationships. These expectations are taken into adulthood.

Good. I was able to use what I had written before dinner. That was quick. Cutting and pasting on the computer. I think I had better print it off and see how it feels.

Maybe I can use more of what I wrote before dinner. Here it is. I had titled it 'Feeling Based Therapy'. I was definitely trying to present my ideas in a formal way. I had reflected on where to start

writing. I thought about the options of listing all the therapies that assert a feeling base or focus, evaluating, comparing and contrasting these therapies and then critiquing them. But even then I felt I had to go to the raison d'être of therapy.

Feeling Based Therapy- The Raison d'Être

People are social beings who need to relate intimately and emotionally with one another. People seek emotional relationships where they will be listened to and accepted as lovable and worthwhile. People come to therapy because they feel that their emotional relationships are not satisfying. It may be relationships at work, or with friends, but more often it is their intimate relationships that are causing them distress.

Although clients describe problems in terms of what other people or they themselves are *doing,* it seems to me that they come to therapy because of their *feelings.* They feel unloved and unvalued. To consider changing their felt experience of that relationship, either by doing things differently, accepting the status quo, or leaving, brings feelings and thoughts about themselves. Thoughts like 'Am I wanting too much?' and feelings of unworthiness, resignation, despair, anger, sadness and numbness. That is how our clients come to us in therapy. In talking about these feelings, clients need to feel a bond with their therapists. They need therapists to listen to them, feel with them and demonstrate that they are unique and valued. They need to connect on an emotional level with their therapists.

I've said it.

Why is there nothing much available in the family therapy literature on the emotional involvement of therapists? Why isn't there an abundance of articles helping therapists consider what has to be done to show clients they are special and worthwhile? What does 'feeling' do to therapists? Is emotional involvement for therapists too hard?

Therapists need to be open, personally, to emotional relationships with clients, to empathise and connect with them. Professionally they need to respect the client's experiences and respond in an open and honest therapeutic manner.

I have learned that to be emotionally involved as a therapist I need to be in a relationship with my client. *To be real.* Real to the client as a person, who has feelings and reactions. I believe therapists have personal and professional responsibilities. The most important responsibility is to be present in my relating to them, respect their experience and respond as openly and honestly as I am able. A bag of therapy techniques doesn't make me real. As a therapist I take me as a person into the room.

Therapists need to be open, personally, to emotional relationships with clients, to empathise and connect with them. Professionally they need to respect the client's experiences and respond in an open and honest therapeutic manner. The fulfilment of these responsibilities make therapists real to their clients.

Clients can tell us how therapists are perceived. They experience and observe their therapists as if their lives depended on them. And their emotional lives do. They come hoping, often unknowingly, that their therapists can share their journey with them.

Where to from here? I could take the more traditional route and look at the literature. In fact I did that. I went on Saturday and did a computer literature search. That made my anxiety rise again. So I went to my friend and colleague and read this to her. My anxiety lessened. And during the week I read it to another colleague and received another good response. During the next week I read and reread what I had said. Towards the end of the week my anxiety started to rise again. I don't want to go to the literature, at least not yet. I want to tell you more about emotional involvement.

I asked my colleagues and clients to reflect on their experiences with therapists. Now, on reflection, I am aware of why I needed to do that. I was not ready to say what I believe emotional involvement in therapy means. I was not ready to say what I have learnt with my clients and struggled with for the past five years. So, I asked these people how they knew their therapist was 'real'. One replied:

'... nobody seemed to notice or care that my involvement was basically superficial until I came to you. How long did it take, before I knew you were interested in something else? Something that really had to do with me? How did you go about letting me know tbat? ... Remember how lucid I was about myself when I first went to see you? ... But it was, essentially, superficial. In the same way I was superficial with my partner. There was no emotional depth. In what ways did you have to be willing to change with me so that it could happen? Honesty. The honesty of your attention to me inside. Whatever it is that makes me feel you're leaning toward me even when you're sitting back. You insisted on the reality of our relationsbip long before I did. What does a therapist do that tells me she is being real? That's hard. How do you describe how the density of the air changes? You, my third therapist, waited patiently for me and with me for about two years before I began to feel a bit safe. The thickness, texture and quality of the air constantly changes.'

The therapy relationship is like air. It is invisible around the therapist and client. Often people only know that the relationship exists when it changes, becoming warmer or colder. This relationship, like air, connects them. Other individuals I questioned wrote about their therapy relationships using terms such as 'feelings', 'intuition' and 'bodily sensations'.

'I'm struggling to know how to do this. My sense of being understood and accepted and my sense that my current therapist is there for me is something that I FEEL. When I reflect on it, I experience sensations in my body, feelings of warmth and safety and cosiness.'

Another wrote:

'The way I know that my therapist is being real with me has more to do with a less visible, more intuitive, or feeling level. In other words for me `knowing' she is being real is relatively independent of the reasoning process. When my therapist is being genuine my experience is one of harmony and congruence between her words and actions, and my experiential sense.

If my therapist attempts to suppress her feelings, to hide them from me and perhaps herself, sbe becomes closed and unavailable emotionally.'

Others noted how 'real' therapists related naturally:

'... the clothes and accessories they wear show their realness. They don't have a professional uniform, the clothes change, the accessories hint at different moods and the make up or hairdo is not always perfect!'

'She shares her experiences and events and reactions from her own relationships. She is natural, laughing, having a joke, showing her tears in the session. She looks me in the eye, making personal observations about me and even about the way I relate to her. She challenges me, disagreeing with me. This tells me she is real ...'

Tears are mentioned many times:

'They (my therapists) feel with me and I know this because they have tears in their eyes or they let out a gasp or utter words with a bitter edge or laugh. This is unguarded responding and lets me know they are with me and not filtering what I say at that moment but letting it in and letting their responses out. Not censoring their responses, being them.'

What is being said is that when therapists are real, clients feel safe and valued. Mostly they say their therapists are showing their feelings in an unguarded manner as they listen. The therapist's way of being made these clients feel real themselves, feeling that they exist as people whom others could relate to. One person spoke of seriousness,

'If I experience being taken seriously then I can trust what's happening in the therapy process. I can allow new things to happen, both in and out of the therapy situation. It gives me greater confidence and empowerment in taking myself seriously. It gives me permission to acknowledge and have parts of myself I couldn't acknowledge or didn't know about before.'

The therapist's conversation is commented on:

'... the words that succeed for me are short, simple; they avoid explanation, they focus on helping me to trace, focus on and express my process, my experience, my emotional reaction.

They (my therapists) stumble around, appearing lost, not appearing to have it all together and burdening me with interpretations, analyses, clever cognitive questions ...'

Therapists struggle to reflect and empathise with their clients on a personal and professional level, responding and questioning to further explore the client's experiences.

Do you relate on an emotional level with your clients? Do you feel with them? Do you feel sadness, anger, hope, or excitement when your clients share their experiences? Do you show your feelings? Do you smile? Show tears? People do these things in their personal relationships. Therapists need to be 'people' in their relationships with their clients. Being

there in that manner makes the clients know their therapists are real.

Realness versus empathy

Empathy has been described by many theorists and therapists, including Rollo, May, Carl Rogers and more recently by Heinz Kohut, as the key to the counselling and therapy process. Rollo May regarded empathy as the general term for the contact, influence and interaction of personalities. He defined empathy as meaning 'feeling into', saying that the therapist's interactions can be viewed as 'walking with another person in the deepest chambers of his soul'. Carl Rogers viewed empathic understanding as one of the five preconditions for therapy to occur. Empathic understanding (not, he asserts, emotional identification) is where the therapist:

'senses accurately the feelings and personal meanings that the client is experiencing and communicates this acceptant understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness'.

In client centred therapy, empathy or empathic understanding is a style of listening. You as therapist 'sense the client's private world as if it were your own, but without ever losing the 'as if quality'.

Rogers talks of empathy as an attitude 'of standing in the other's shoes, of viewing the world through the [other's] eyes'. This phrase 'standing in the other's shoes' excites me. However, my excitement soon fades when Rogers describes this process of empathic understanding: 'where the counsellor perceives the hates and hopes and fears of the client through immersion in an empathic process, but without himself, as counsellor, experiencing those hates and hopes and fears'. Throughout his writing, he stresses the point of leaving the person of the therapist out:

'where the therapist endeavours to keep himself out, as a separate person, and where his whole endeavour is to understand the other so completely that he becomes almost an alter ego of the client, personal distortions and maladjustment are much less likely to occur'.

But if we are without our self as therapist, who are we? How can a therapist perceive or even, for that matter, feel, without having themselves present? How does a therapist be 'as if?' Is this pretence?

Kohut also emphasised empathy, regarding it as having a central place in the theory and therapy of self psychology, although stating that empathy is both an information-gathering activity and a powerful emotional bond between two people, goes on to deal only with empathy as a mode of observation. Ken Bragan notes that Kohut's comments on spontaneous and warm reactions on the part of the therapist as constituting the environment of therapy, were withdrawn in later articles. He concludes that although Kohut saw empathy as an instrument for observing and as a mode of relatedness, ultimately for him it was a cognitive instrument for perception. In other words, for self psychologists, empathy is a form of listening, a form of participation, without the person of

the therapist. Like client centred therapy, self psychology appears to require the therapist to form an involvement, an attachment, without the therapist being a person in the room. Without being real.

In other words, empathy or vicarious introspection, for self psychology and client centred therapy, is a means to gather data on the client, a way to know more about the client than the client themselves.

Through relating to clients, therapists will be challenged about the way they deal with unacknowledged fears of intimacy or confrontation. They will change and be changed by their encounters with clients.

Bachelor analysed and classified empathy. Some responses were classified as 'Perceived cognitive empathy', where the therapist expressed their understanding by questions, responses and interpretations. Two other classifications were 'perceived sharing empathy', where the therapist discloses personal opinions and experiences, and 'perceived affective empathy', which are therapist responses that mirror the client's feelings.

Is showing the client that you are feeling the same feeling anything more than mirroring the client? Does showing the same feeling tell the client their therapist is emotionally involved? I'm not sure it does.

I think that writers have been grappling with this notion of realness. Although Mark Miller asserted that who you are in the therapy relationship is as important as what you do, his writing about empathy appears confused. He begins by saying empathy is not a communication process but the capacity to experience a feeling, comprehend it and then react to it but then concludes by saying empathy is an attitude. However, it is Marilyn Lammert who really grapples with the issue of the therapist being a person. She talks of 'experiencing as knowing': Experiencing for the therapist involves being open and aware of one's own as well as the client's experience. Lammert states that the therapist has a number of tasks: being aware of her/his own experiences and sensing the client's private world as if it were his/her own. But then she recommends that the therapist needs to separate those feelings and sensations, holding those that belong to him/herself and sharing only those that relate to the client.

Albert Rothenberg takes this one step further by saying that the therapist needs to experience a subjective sense of feeling as the patient did, and more importantly, mentally superimpose his self representation with the patient representation. Rothenberg states that this is done not by thinking 'How would I feel if I were in the patient's shoes?' but with a fullblown and active feeling into the patient, by superimposing himself into their experience. But

unfortunately he stops short by then suggesting the therapist use this information to 'enlarge the scope of inquiry' for the patient, by making more informed or accurate interpretations.

Let us go back to his term 'superimpose the self.' My understanding of what he is saying is that we feel ourselves in the client's shoes as we become the client. It is my belief that we need to 'become the client'. Therapists 'become the client' by hearing their client's story, how they feel and what they make of their feelings, so we can walk in their journey, walk in their story, and in so doing experience what it is like being them. In this manner there is a real entering into the life of another.

And that is where realness is crucial. Therapists must put themselves as a person into the client's shoes in order to deeply feel with their most inner self the experiences shared with them by their client. When we are with someone who is split off from their feelings and inner experience we can only intuit and know some elements of their experience when we step into their shoes as ourselves. That is, if we are not split off from our own emotional experiences.

Being real, being emotionally involved as a person and therapist is not a facet of empathy. It is more than empathy.

I wonder why these writers have stopped short of saying that we become the client. All I know from my experience and from others is that clients seek their therapist's emotional involvement, their realness. They want to know how the therapist feels. How they know the therapist feels and experiences them is by the consistency and congruency in tone of voice, words and actions. They feel a sense of oneness, the same oneness we sought in our early relationship with our Mum. And in knowing and experiencing this with us, clients feel safe to take their next steps forward.

So let us consider the person as therapist.

The Person as Therapist

There are specific things my colleagues and clients wrote when they reflected on the role of the therapist. They spoke of confidence and control:

'... indicating she knows what she is doing and doesn't fluster and flounder. Some assurance she is in control of the session in the sense of keeping her eye on the time, not letting me start something huge a few minutes before the end.'

They also spoke of competence:

'... also that she makes connections and draws threads togetber and follows me where I go but can draw me back from dead ends or blind alleys.'

'... moves the session by their 'knowing' about what I need, to reach some conclusion, understand a pattern or feel a feeling, what will help me process my experience.'

More importantly they spoke of boundaries between them and their therapist:

'... not letting me feel I need to look after her or protect her or help her or boost her confidence. I need to feel or sense a strength and wisdom and centredness in the therapist and clearness of her boundaries.'

These are the shoes that therapists wear. Shoes made of both personal and professional materials. One without the

other can make the therapist's shoes too tight or too stiff to bend and change during the therapy process.

Other responses dealt with the lack of realness when therapists act as 'therapists' in the pejorative sense, being professionals without the personal part, without being real.

'... I do get annoyed with a therapist who jerks out of being 'real' into playing the role of therapist because it is the end of the session. I feel they do it just to get rid of me and I am ashamed..'

'... their approach is structured or systemic without any concession to how I am feeling.'

'... interpretations or feedback expressed as fact or learned opinions with the attitude that they, as therapist, know best.'

'... bodily stiffness and absolute uncompromising occupation of the power chair with their most favoured appendage, the clipboard.'

The message is clear. Clients experience therapists who are not real as detached, opinionated and judgemental. These therapists' shoes are experienced as heavy boots. Alice Miller said so very clearly that we should listen to the patient and not to any theory; with our theory we are not free to listen.

The Therapist as Person

By bringing themselves into the session, therapists are potentially able to take themselves into their client's experience, stepping into *their* shoes. At that moment, they are 'becoming' the client, experiencing the client's feelings while feeling their own. These can match the client's or they can be different and therapists need to decide how they use them.

The therapist's sharing of feelings and experiences can be beneficial. It can help draw out the clients' hidden and unaccessed emotions. However, I have found that the opposite may occur if I haven't first stepped into my clients' experiences. It becomes detrimental, with clients feeling inadequate or criticised. They end up experiencing my shoes as boots which trample on their blue suede shoes.

And it is here I realise that some of my earlier anxiety in writing this was about having to grapple with my most recent errors with my clients, where I shared my own personal experiences prematurely, not shared my feelings as I became them. Or where I stepped away from 'becoming' them and tried to be with them in a cognitive way. And this I believe is about boundaries.

I believe that the reasons therapists share inappropriately, are detached, or only relate intellectually are connected to their feelings about themselves. Therapists who are struggling with their own sense of themselves will not be able to relate therapeutically to their clients. They will not be aware which shoes they are wearing. Therapists need to be aware of and deal with their own experiences, feeling the pain and loss of their unmet and unsatisfied needs. They need to become committed to their journey of inner knowledge and to the continued development of their inner and outer selves. In this manner, they become congruent with themselves.

The knowledge gained in this process allows therapists to concentrate on the inner needs of clients, rather than their own. While doing this, therapists learn more about themselves, how they step back or make premature comments.

Through relating to clients, therapists will be challenged about the way they deal with unacknowledged fears of intimacy or confrontation. They will change and be changed by their encounters with clients. They will get to know how and when to distance themselves or kick out.

It is not that therapists need to be totally self-aware. It is more that therapists need to be aware of how they react emotionally with clients. They need to invite both favourable and unfavourable comments about this, and in the light of this feedback, they develop their abilities to be real. As Peter Lomas says,'Once we take seriously the emotional dimension in therapy, the technical paradigm is revealed as inadequate and any alternative model will have to be of a personal nature'. Taking seriously the emotional dimension of therapy means that the therapist's inner person needs to be involved, as with all other emotional relationships.

Therapists need to ensure that their work environments are structured supportively to allow the development of real therapeutic relationships. They need supervisors who can relate to them personally and professionally. Most importantly, therapists need to continue their own therapy as required. This will enable them to know their own blue suede shoes as well as their client's. Only then will therapists freely respect and care for their clients.

Slowly I've realised as I've read, re-read and felt my experiences, that I have leamt more about some of my errors with my clients. I have become more fully aware of the importance of being emotionally involved with my clients by being myself. Taking myself into the therapy room with me as the therapist and letting myself be real with them.

I believe the questions therapists must address are: What are clients saying about us as people as well as therapists? What are we doing with their comments and reactions? Do we have the confidence to be real with clients? As you have read this, what have been your reactions? It is these reactions which make us real with each other and with our clients.

There. It's done. I've said it. Actually, I have been feeling my way through, feeling and reflecting on my emotional reactions to what I have said or wanted to say, and with what I have assembled from these client comments and from the literature on empathy.

Where does this leave me? Feeling better about my way of being as a therapist. Knowing it is not my personal countertransferential reactions or unfinished emotional needs that are behind my insistence on therapist realness. Feeling better about my therapeutic errors as I now understand what occurred. Feeling calmer in the knowledge that a therapist is required to be 'in relationship' with their client in order to provide a professional service.

I wonder what has been happening to you, as reader? What did you feel as you read this article? Have you been using your internal reactions or have you been more detached from your feeling self? Have you been remembering your personal experiences of therapy and what your clients have said to you about their requirements of being 'in relationship' with you? About your presence as a therapist? About your 'blue suede shoes'?

the regular COLUMN

Moira Lake has been, among other things, a professional astrologer, healer, factory worker, editor, office cleaner, mental health researcher and malcontent. She now practises as a UKCP registered psychotherapist and supervisor in Kingston-upon-Thames. She is a member of the Ecopsychology Group of Psychotherapists and Counsellors for Social Responsibility. This year she will write a regular column in S&S - next year it's someone else.

We humans don't know much about living together well, and raising children in safety and love. But one thing we do know, mostly from personal experience: the heterosexual nuclear family, as a normative model, *does not work*. Most of us are casualties of heterosexual nuclear families (HNFs), and many have produced further casualties. As therapists we spend most of our time trying to help clients heal from the wounds sustained within HNF families.

Yet most professionals of all sorts, and the public at large, are committed to preserving the HNF as the core social unit, relegating other social groupings to a tolerated periphery. Why?

How come we are trying so hard to sustain a system which, even when it flourished, served men at the cost of crushing abuse of women and children, and now no longer serves even men?

Here, I think, are the main arguments for the HNF model. Firstly, at present (despite well-documented cases of parthenogenesis) most women cannot reproduce without involving men. This primal link serves to inhibit the growing separation of men and women, which current trends would otherwise indicate to our mutual loss. But this reproductive necessity, and the pleasures of heterosexual sex, can flourish independently of the HNF as a social model.

Secondly, the HNF model offers the convenience of institutionalised projection. No citizen need be more than half a complete person, as the

---

Blue Suede Shoes continued ...

Acknowledgments

I wish to thank my colleagues and clients at the Counselling Training Centre (NSW) for their comments on their experience of therapy and the editors for their assistance.

Further Reading

Bachelor, A. 1988. How Clients Perceive Empathy: A Content Analysts of 'Received' Empathy, *Psychotherapy,* 25, 2: 227-240.

Bragan, K. 1987. I and Thou: An Examination of Empathy, *The Australian and New Zealand Journal of Psychiatry,* 21: 575-579.

Kirschenbaum, H. and Henderson, V. L. 1990. *The Carl Rogers Reader,* London, Constable.

Kohut, H. 1982. Introspection, Empathy and the Semicircle of Mental Health, *International Journal of Psycho-Analysis,* 63: 395-408.

Lammert, M. 1986. Experience as Knowing: Utilizing Therapist SelfAwareness, *Social Casework. The Journal of Contemporary Social Work,* June: 369-376.

Lomas, R. 1987. *The Limits of Interpretation,* Harmondsworth, Penguin.

May, R. 1939. *The Art of Counselling,* NY, Abingdon Press.

other half, clearly delineated in gender codes, can be attributed to the partner. As all participants, including children, are disempowered in this process, it has been a useful tool of social control. However, as the genders explore more fluid ways of relating, this may be an atrophying function of the HNF.

Thirdly, in the last century it became widely known that, regardless of sexual orientation, women naturally turn to women, and men to men, for deep experiences of emotional bonding. This is essentially hostile to capitalism, which requires that people be offered frustrating, competitive and isolating experiences, where satisfaction appears to lie only in the consumption of goods. Women must be set against women and men against men. The needs of children, of course, are best betrayed by those who are themselves abandoned, and the success of this approach can be seen in the 'pester power' of children today. A base social unit which thwarts communication and intimacy is essential if the capitalist project is to be sustained. This is probably the strongest current argument for HNFs.

But perhaps the profoundest cause of our attachment to the HNF model lies in our human psyche. We love the HNF model precisely because it does not work. Our longing leads so many of us, nursing the needs unmet in our families, to seek a new, good one. Failing again makes us try again. If we could accept that the disasters are intrinsic to this model, cunningly built into it, we might be able to demote it from the status of 'norm' to just one possible choice, freely available from among a proliferation of loving and creative social forms.

Miller, A. 1985. *Thou Shalt Not Be Aware,* London, Pluto Press.

Miller, M. 1989. A Few Thoughts on the Relationship between Counselling Techniques and Empathy, *Journal of Counselling and Development,* 67: 350-351.

Rogers, C. R. 1951. *Client-Centered Therapy,* London, Houghton and Miflin.

Rogers, C. R. and Stevens, B. 1967. *Person to Person., The Problem of Being Human,* Lafayette, CA, Real People Press.

Rothenberg, A. 1987. Empathy as a Creative Process in Treatment, *International Review of Psycho-Analysis,* 14: 445-461.

Swann, J. 1982. Shoes, Frome, Somerset, Butler and Tanner. A Batsford Book

Winnicott, D. W. 1964. *The Child, the Family, and the Outside World,* Harmondsworth, Penguin.

Michelle Webster is a registered psychologist in private practice as an individual and couple therapist, supervisor and trainer at the Counselling Training Centre (NSW). Please contact Counselling Training Centre (NSW), PO Box 97 Annandale NSW 2038 for a copy of the complete 'Blue Suede Shoes' paper as presented at the Sixth National Conference of AAMFC and the Second Australian and New Zealand Family Therapy Conference, 1992.