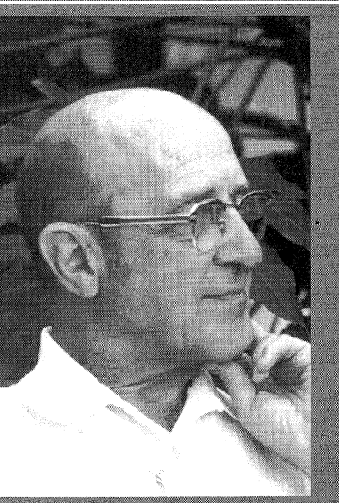

Carl R. Rogers, 1902–1987

5 CLIENT-CENTERED THERAPY

Nathaniel J. Raskin, Carl R. Rogers, and Marjorie C. Witty

OVERVIEW

In 1940, at a conference for educators and psychologists at the University of Minnesota, Carl Ransom Rogers presented his revolutionary theory of therapy. Since that time, his theory has variously been called nondirective therapy, client-centered therapy, and the person-centered approach. Rogers's hypothesis states that a congruent therapist who expresses attitudes of unconditional positive regard and empathic understanding within a genuine relationship will catalyze psychotherapeutic personality change in a vulnerable, incongruent client. This hypothesis has been confirmed over decades in work with individuals of all ages, and with couples, families, and groups. The democratic, nonauthoritarian values inherent in this theory result in an approach to therapy that honors the persons' right to self-determination and psychological freedom.

Basic Concepts

The Person

The foundation of the approach is grounded in the perspective of human persons as active, self-regulating organisms. "[T]he image of the human being as a *person*" differentiates client-centered theory from approaches which reduce the person to diagnostic categories (Schmid, 2003, p. 108).

Based on the work of Kurt Goldstein (1934/1959) and his own observations of clients, Rogers postulated that all living organisms are dynamic processes motivated by an inherent tendency to maintain and enhance themselves. This *actualizing tendency* functions continually and holistically throughout all subsystems of the organism. Rogers (1980) speculated that the actualizing tendency is part of a more general *formative tendency,* observable in the movement toward greater order, complexity, and interrelatedness that occurs in stars, crystals, and microorganisms as well as in human beings. Persons are constantly evolving toward greater complexity, fulfilling those potentials that preserve and enhance themselves.

The Therapist

The client-centered therapist trusts the person's inner resources for growth and self-realization, in spite of his or her impairments or environmental limitations. The therapist's belief in the client's inherent growth tendency and right to self-determination is expressed, in practice, through commitment to "the nondirective attitude" (Raskin, 1947, 1948; Rogers, 1951). If the aims of psychotherapy are to free the person for growth and development, one cannot employ disempowering means in the service of emancipatory ends.

To be a client-centered therapist is to risk meeting the client as a person, to be of service in an authentic, collaborative relationship. It is the difference between *using* techniques to achieve certain ends and *being* oneself in relation to another person.

To undertake to develop as a client-centered therapist, one must be willing to take on the discipline of learning to be an open, authentic, empathic person who implements these attitudes in the relationship. Rogers described this empathic orientation as a "way of being" (Rogers, 1980). In client-centered therapy, unconditional positive regard and empathic understanding are neither techniques nor aspects of a professional role. To be effective, they must be real. The discipline consists of inhibiting the desire to show power, to use the client in any way, or to view the client in terms of reductionist categories that diminish the person's status as a human (Grant, 1995).

The Relationship

Psychotherapy outcome research supports Rogers's hypothesis that the therapeutic *relationship* accounts for a significant percentage of the variance in positive outcome in all theoretical orientations of psychotherapy (Asay & Lambert, 1999, p. 31).

In practice, the therapist's implementations of the therapeutic attitudes creates a climate of freedom and safety. Within this climate, the client is the active narrator of meanings, goals, and intentions. The client propels the process of self-definition and differentiation. Bohart elucidates the client's active, self-healing activities which, in interaction with the therapist-provided conditions, promote positive change. In this interactive, synergistic model, the client actively co-constructs the therapy (Bohart, 2004, p. 108).

Because both the therapist and the client are unique persons, the relationship that develops between them cannot be prescribed by a treatment manual. It is a unique, unpredictable encounter premised on the response of the therapist to a person who seeks help. Client-centered therapists tend to be spontaneously responsive and accommodating to the requests of clients whenever possible. This willingness to accommodate requests—by answering questions, by changing a time or making a phone call on behalf of a client—originates in the therapist's basic trust in and respect for the client.

On a practical level, practitioners of client-centered therapy trust that individuals and groups are fully capable of articulating and pursuing their own goals. This has special meaning in relation to children, students, and workers, who are often viewed as requiring constant guidance and supervision. The client-centered approach endorses the person's right to choose or reject therapy, to choose a therapist whom he or she thinks may be helpful (sometimes a person of the same age, race, gender, or sexual orientation), to choose the frequency of sessions and the length of the therapeutic relationship, to speak or to be silent, to decide what needs to be explored, and to be the architect of the therapy process itself. Clients can talk about whatever they wish, whatever is present for them at the current moment. Similarly, when the therapeutic conditions are present in a group and when the group is trusted to find its own way of being, group members tend to develop processes that are right for them and to resolve conflicts within time constraints in the situation.

The Core Conditions

Congruence

> *Congruence*, *unconditional positive regard*, and *empathic understanding of the client's internal frame of reference* are the three therapist-provided conditions in client-centered therapy. There is a vast literature investigating the efficacy of what have grown to be called "the core conditions" (Patterson, 1984). Although they are distinguishable, these three attitudes function holistically as a gestalt in the experience of the therapist (Rogers, 1957).

Congruence represents the therapist's ongoing process of assimilating, integrating, and symbolizing the flow of experiences in awareness. Rogers states, "To me being congruent means that I am aware of and willing to represent the feelings I have at the moment. It is being real and authentic in the moment" (Baldwin, 1987, p. 51).

A psychotherapist who is aware of the inner flow of experiencing and who is acceptant toward these inner experiences can be described as integrated and whole. Thus, even when the therapist experiences a lack of empathic understanding or even dislike for the client, if these experiences are allowed into awareness without denial or distortion, the therapist meets Rogers's condition of congruence (Brodley, 2001, p. 57). The therapist's congruence usually manifests itself in the outward appearance of transparency or genuineness and in the behavioral quality of relaxed openness. As therapist congruence persists over time, the client learns that the therapist's apparent openness is genuine and that the therapist is not covertly "up to" anything regarding the client.

Unconditional Positive Regard

The therapist enters into a relationship with the client hoping to experience *unconditional positive regard* for the client. This construct refers to a warm appreciation or prizing of the other person. The therapist accepts the client's thoughts, feelings, wishes, intentions, theories, and attributions about causality as unique, human, and appropriate to the present experience. The client may be reserved or talkative, may address any issue, and may come to whatever insights and resolutions are personally meaningful. Ideally, the therapist's regard for the client will not be affected by these particular choices, characteristics, or outcomes. Complete, unswerving unconditionality is an ideal, but in seeking to realize this ideal attitude, therapists find that their acceptance, respect, and appreciation for clients deepens with the growth of understanding.

The therapist's ability to experience unconditional positive regard toward a particular client, which is reliably present over time, is a developmental process involving a commitment to eschew judgmental reactions and to learn to inhibit critical responses that often emerge in common life situations. The novice therapist makes a commitment to expand his or her capacity for acceptance, to challenge his or her automatic judgments and biases, and to approach each client as a unique person doing the best he or she can under circumstances as they perceive them and that are affecting them even though they may not be aware of them.

Basic concepts on the client side of the process include *self-concept, locus of evaluation,* and *experiencing.* In focusing on what is important to the person seeking help, client-centered therapists soon discovered that the person's perceptions and feelings about self were of central concern (Raimy, 1948; Rogers, 1951, 1959b). A major component of one's self-concept is self-regard, often lacking in clients who seek therapeutic help. Some of the earliest psychotherapy research projects showed that when clients were rated as successful in therapy, their attitudes toward self became significantly more positive (Sheerer, 1949). More recent research underscores this important aspect of positive therapy outcome.

Ryan and Deci's self-determination theory (SDT) has stimulated numerous studies demonstrating that psychological well-being is associated with the satisfaction of basic needs for autonomy, competence, and relatedness, conceptions that are integrally related to Rogers's notion of the *fully functioning person* (Deci & Ryan, 1985, 1991). The client-centered therapist's experiencing of the core conditions expressed as a gestalt and informed by the nondirective attitude creates an optimal environment for the expression of these basic needs that enhance self-determination for both therapist and client (Ryan & Deci, 2000).

> Comparisons between people whose motivation is *authentic* (literally, self-authored or endorsed) and those who are merely *externally controlled* for an action typically reveal that the former, relative to the latter, have more interest, excitement, and confidence which in turn is manifest both as enhanced performance, persistence, and creativity (Deci & Ryan, 1991; Sheldon, Ryan, Rawsthorne, & Ilardi, 1997) and as heightened vitality (Nix, Ryan, Manly, and Deci, 1999), self-esteem (Deci & Ryan, 1995), and general well-being (Ryan, Deci, & Grolnick, 1995). This is so even when people have the same level of perceived competence or self-efficacy for the activity. (Ryan & Deci, 2000, p. 69)

Rogers's group also found that clients tended to progress along a related dimension termed *locus of evaluation.* As they gained self-esteem, they tended to shift the basis for their standards and values from other people to themselves. People commonly began therapy overly concerned with what others thought of them; that is, their locus of evaluation was external. With success in therapy, their attitudes toward others, as toward themselves, became more positive, and they were less dependent on others for their values and standards (Raskin, 1952).

A third central concept in client-centered therapy is *experiencing,* a dimension along which many but not all clients improved (Rogers, Gendlin, Kiesler, & Truax, 1967), shifting from a rigid mode of experiencing self and world to one of greater openness and flexibility.

The therapeutic attitudes and the three client constructs described in this section have been carefully defined, measured, and studied in scores of research projects relating therapist practice to the outcome of psychotherapy. There is considerable evidence that when clients perceive unconditional positive regard and empathic understanding in a relationship with a congruent therapist, their self-concepts become more positive and

realistic, they become more self-expressive and self-directed, they become more open and free in their experiencing, their behavior is rated as more mature, and they cope more effectively with stress (Rogers, 1986a).

Other Systems

Client-centered therapy evolved predominantly out of Rogers's own experience as a practitioner. There are both important differences and conceptual similarities between the person-centered approach and other personality theories.

Self-actualization, a concept central to person-centered theory, was advanced most forcefully by Kurt Goldstein. His holistic theory of personality emphasizes that individuals must be understood as totalities that strive to actualize themselves (Goldstein, 1934/1959). Goldstein's work and ideas prefigured those of Abraham Maslow, a founder of humanistic psychology, who opposed Freudian and stimulus/response interpretations of human nature, asserting instead that persons seek out meaning, valuing, transcendence, and beauty.

Heinz Ansbacher, a leading proponent of Adlerian theory, joined Maslow (1968) and Floyd Matson (1969) in recognizing a host of theories and therapists "united by six basic premises of humanistic psychology":

1. People's creative power is a crucial force, in addition to heredity and environment.
2. An anthropomorphic model of humankind is superior to a mechanomorphic model.
3. Purpose, rather than cause, is the decisive dynamic.
4. The holistic approach is more adequate than an elementaristic one.
5. It is necessary to take humans' subjectivity, their opinions and viewpoints, and their conscious and unconscious fully into account.
6. Psychotherapy is essentially based on a good human relationship (Ansbacher, 1977, p. 51).

Among those subscribing to such beliefs were Alfred Adler, William Stern, and Gordon Allport; the gestalt psychologists Max Wertheimer, Wolfgang Kohler, and Kurt Koffka; the neo-Freudians Franz Alexander, Erich Fromm, Karen Horney, and Harry Stack Sullivan; post-Freudians such as Judd Marmor and Thomas Szasz; phenomenological and existential psychologists such as Rollo May; the cognitive theorist George A. Kelly, and of course Carl Rogers (Ansbacher, 1977).

Meador and Rogers (1984) distinguished client-centered therapy from psychoanalysis and from behavior modification in these terms:

> In psychoanalysis the analyst aims to interpret connections between the past and the present for the patient. In client-centered therapy, the therapist facilitates the client's discoveries of the meanings of his or her own current inner experiencing. The psychoanalyst takes the role of a teacher in interpreting insights to the patient and encouraging the development of a transference relationship, a relationship based on the neurosis of the patient. The person-centered therapist presents him- or herself as honestly and transparently as possible and attempts to establish a relationship in which he or she is authentically caring and listening.
>
> In client-centered therapy, transference relationships may begin, but they do not become full-blown. Rogers has postulated that transference relationships develop in an evaluative atmosphere in which the client feels the therapist knows more about the client than the client knows about him- or herself, and therefore the client becomes dependent, repeating the parent–child dynamic of the past.

> Person-centered therapists tend to avoid evaluation. They do not interpret for clients, do not question in a probing manner, and do not reassure or criticize clients. Person-centered therapists have not found the transference relationship, [which is] central to psychoanalysis, a necessary part of a client's growth or change.
>
> In behavior therapy, *behavior change* comes about through external control of associations to stimuli and the consequences of various responses. In practice, if not in theory, behavior therapy *does* pay attention to the therapy relationship; however, its major emphasis is on specific changes in behaviors. In contrast, person-centered therapists believe behavior change evolves from within the individual. Behavior therapy's goal is symptom removal. It is not particularly concerned with the relationship of inner experiencing to the symptom under consideration, or with the relationship between the therapist and the client, or with the climate of their relationship. It seeks to eliminate the symptom as efficiently as possible using the principles of learning theory. Obviously, this point of view is quite contrary to person-centered therapy, which maintains that fully functioning people rely on inner experiencing to direct their behavior. (Meador & Rogers, 1984, p. 146)

Raskin (1974), in a study comparing Rogers's therapy with those of leaders of five other orientations, found that client-centered therapy was distinctive in providing empathy and unconditional positive regard. Psychoanalytically oriented and eclectic psychotherapists agreed with client-centered theory on the desirability of empathy, warmth, and unconditional positive regard, but examples of rational emotive, psychoanalytically oriented, and Jungian interviews were ranked low on these qualities.

This study provided a direct comparison of audiotaped samples of therapy done by Rogers and Albert Ellis, the founder of rational emotive behavior therapy (REBT). Among 12 therapist variables rated by 83 therapist-judges, the only one on which Rogers and Ellis were alike was Self-Confident. The therapy sample by Rogers received high ratings on the following dimensions: Empathy, Unconditional Positive Regard, Congruence, and Ability to Inspire Confidence. The interview by Ellis was rated high on the Cognitive and Therapist-Directed dimensions. Rogers was rated low on Therapist-Directed, and Ellis received a low rating on Unconditional Positive Regard.

This research lends support to the following differences between client-centered therapy and rational emotive behavior therapy.

1. Unlike REBT, the person-centered approach greatly values the therapeutic relationship.
2. Rational emotive therapists provide much direction, whereas the person-centered approach encourages the client to determine direction.
3. Rational emotive therapists work hard to point out deficiencies in their clients' thought processes; person-centered therapists accept and respect their clients' ways of thinking and perceiving.
4. Client-centered therapy characteristically leads to actions chosen by the client; rational emotive methods include "homework" assignments by the therapist.
5. The person-centered therapist relates to the client on a feeling level and in a respectful and accepting way; the rational emotive therapist is inclined to interrupt this affective process to point out the irrational harm that the client may be doing to self and to interpersonal relationships.

Although Rogers and Ellis have very different philosophies and methods of trying to help people, they share some very important beliefs and values:

1. A great optimism that people can change, even when they are deeply disturbed
2. A perception that individuals are often unnecessarily self-critical and that negative self-attitudes can become positive

realistic, they become more self-expressive and self-directed, they become more open and free in their experiencing, their behavior is rated as more mature, and they cope more effectively with stress (Rogers, 1986a).

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3. A willingness to put forth great effort to try to help people, both through individual therapy and through professional therapy and nontechnical writing
4. A willingness to demonstrate their methods publicly
5. A respect for science and research

Similar differences and commonalities are found when Rogers is compared to other cognitive therapists, such as Aaron Beck.

HISTORY

Precursors

One of the most powerful influences on Carl Rogers was learning that traditional child-guidance methods in which he had been trained did not work very well. At Columbia University's Teachers College, he had been taught testing, measurement, diagnostic interviewing, and interpretive treatment. This was followed by an internship at the psychoanalytically oriented Institute for Child Guidance, where he learned to take exhaustive case histories and do projective personality testing. It is important to note that Rogers originally went to a Rochester child-guidance agency believing in this diagnostic, prescriptive, professionally impersonal approach, and only after actual experience did he conclude that it was not effective. As an alternative, he tried listening and following the client's lead rather than assuming the role of the expert. This worked better, and he discovered some theoretical and applied support for this alternative approach in the work of Otto Rank and his followers at the University of Pennsylvania School of Social Work and the Philadelphia Child Guidance Clinic.

One particularly important event was a three-day seminar in Rochester with Rank (Rogers & Haigh, 1983). Another was his association with a Rankian-trained social worker, Elizabeth Davis, from whom "I first got the notion of responding almost entirely to the feelings being expressed. What later came to be called the reflection of feeling sprang from my contact with her" (Rogers & Haigh, 1983, p. 7).

Rogers's therapy practice and, later, his theory grew out of his own experience. At the same time, a number of links to Otto Rank are apparent in Rogers's early work.

The following elements of Rankian theory bear a close relationship to principles of nondirective therapy.

1. The individual seeking help is not simply a battleground of impersonal forces such as the id and superego, but has personal creative powers.
2. The aim of therapy is acceptance by the individual of self as unique and self-reliant.
3. In order to achieve this goal, the client rather than the therapist must become the central figure in the therapeutic process.
4. The therapist can be neither an instrument of love, which would make the client more dependent, nor an instrument of education, which attempts to alter the individual.
5. The goals of therapy are achieved by the client not through an explanation of the past, which the client would resist if interpreted, and which, even if accepted, would lessen responsibility for present adjustment, but rather through experiencing the present in the therapeutic situation (Raskin, 1948, pp. 95–96).

Rank explicitly, eloquently, and repeatedly rejected therapy by technique and interpretation:

> Every single case, yes every individual hour of the same case, is different, because it is derived momentarily from the play of forces given in the situation and immediately

> applied. My technique consists essentially in having no technique, but in utilizing as much as possible experience and understanding that are constantly converted into skill but never crystallized into technical rules which would be applicable ideologically. There is a technique only in an ideological therapy where technique is identical with theory and the chief task of the analyst is interpretation (ideological), not the bringing to pass and granting of experience. (1945, p. 105)

Rank is obscure about his actual practice of psychotherapy, particularly the amount and nature of his activity during the treatment hour. Unsystematic references in *Will Therapy, Truth and Reality* (1945) reveal that, despite his criticism of educational and interpretive techniques and his expressed value of the patient being his or her own therapist, he assumed a position of undisputed power in the relationship.

Beginnings

Carl Ransom Rogers was born in Oak Park, Illinois, on January 8, 1902. Rogers's parents believed in hard work, responsibility, and religious fundamentalism and frowned on activities such as drinking, dancing, and card playing. The family was characterized by closeness and devotion but did not openly display affection. While in high school, Carl worked on the family farm, and he became interested in experimentation and the scientific aspect of agriculture. He entered the University of Wisconsin, following his parents and older siblings, as an agriculture major. Rogers also carried on his family's religious tradition. He was active in the campus YMCA and was chosen to be one of 10 American youth delegates to the World Student Christian Federation's Conference in Peking, China, in 1922. At that time he switched his major from agriculture to history, which he thought would better prepare him for a career as a minister. After graduating from Wisconsin in 1924 and marrying Helen Elliott, a childhood friend, he entered the Union Theological Seminary. Two years later, and in part as a result of taking several psychology courses, Rogers moved "across Broadway" to Teachers College, Columbia University, where he was exposed to what he later described as "a contradictory mixture of Freudian, scientific, and progressive education thinking" (Rogers & Sanford, 1985, p. 1374).

After Teachers College, Rogers worked for 12 years at a child-guidance center in Rochester, New York, where he soon became an administrator as well as a practicing psychologist. He began writing articles and became active at a national level. His book *The Clinical Treatment of the Problem Child* was published in 1939, and he was offered a professorship in psychology at Ohio State University. Once at Ohio State, Rogers began to teach newer ways of helping problem children and their parents.

In 1940, Rogers was teaching an enlightened distillation of the child-guidance practices described in *The Clinical Treatment of the Problem Child.* From his point of view, this approach represented a consensual direction in which the field was moving and was evolutionary rather than revolutionary. The clinical process began with an assessment, including testing children and interviewing parents; assessment results provided the basis for a treatment plan. In treatment, nondirective principles were followed.

Rogers's views gradually became more radical. His presentation at the University of Minnesota on December 11, 1940, entitled "Some Newer Concepts in Psychotherapy," is the single event most often identified with the birth of client-centered therapy. Rogers decided to expand this talk into a book titled *Counseling and Psychotherapy* (1942). The book, which included an electronically recorded eight-interview case, described the generalized process in which a client begins with a conflict situation and a predominance of negative attitudes and moves toward insight, independence, and positive attitudes. Rogers hypothesized that the counselor promoted such a process

by avoiding advice and interpretation and by consistently recognizing and accepting the client's feelings. Research corroborating this new approach to counseling and psychotherapy was offered, including the first (Porter, 1943) of what soon became a series of pioneering doctoral dissertations on the process and outcomes of psychotherapy. In a very short time, an entirely new approach to psychotherapy was born, as was the field of psychotherapy research. This approach and its accompanying research led to the eventual acceptance of psychotherapy as a primary professional function of clinical psychologists.

After serving as director of counseling services for the United Service Organizations during World War II, Rogers was appointed professor of psychology at the University of Chicago and became head of the university's counseling center. The 12 years during which Rogers remained at Chicago were a period of tremendous growth in client-centered theory, philosophy, practice, research, applications, and implications.

In 1957, Rogers published a classic paper entitled "The necessary and sufficient conditions of therapeutic personality change." Congruence, unconditional positive regard, and empathic understanding of the client's internal frame of reference were cited as three essential therapist-offered conditions of therapeutic personality change. This theoretical statement applied to all types of therapy, not just the client-centered approach. It was followed by his "magnum opus," the most comprehensive and rigorous formulation of his theory of therapy, personality, and interpersonal relationships (Rogers, 1959b).

Rogers's philosophy of the "exquisitely rational" nature of the behavior and growth of human beings was further articulated and related to the thinking of Søren Kierkegaard, Abraham Maslow, Rollo May, Martin Buber, and others in the humanistic movement whose theories were catalyzing a "third force" in psychology, challenging the dominance of behaviorism and psychoanalysis.

As the practice of client-centered therapy deepened and broadened, the therapist was also more fully appreciated as a person in the therapeutic relationship. Psychotherapy research, which had begun so auspiciously at Ohio State, continued with investigations by Godfrey T. Barrett-Lennard (1962), John Butler and Gerard Haigh (1954), Desmond Cartwright (1957), Eugene Gendlin (1961), Nathaniel Raskin (1952), Julius Seeman (1959), John Shlien (1964), and Stanley Standal (1954), among others.

At Ohio State, there was a sense that client-centered principles had implications beyond the counseling office. At Chicago, this was made most explicit by the empowerment of students and the counseling center staff. About half of Rogers's *Client-Centered Therapy* (1951) was devoted to applications of client-centered therapy, with additional chapters on play therapy, group therapy, and leadership and administration.

In 1957, Rogers accepted a professorship in psychology and psychiatry at the University of Wisconsin. With the collaboration of associates and graduate students, a massive research project was mounted, based on the hypothesis that hospitalized schizophrenics would respond to a client-centered approach (Rogers et al., 1967). Two relatively clear conclusions emerged from a complex maze of results: (1) the most successful patients were those who had experienced the highest degree of accurate empathy, and (2) it was the client's, rather than the therapist's, judgment of the therapy relationship that correlated more highly with success or failure.

Rogers left the University of Wisconsin and full-time academia and began living in La Jolla, California, in 1964. He was a resident fellow for four years at the Western Behavioral Sciences Institute and then, starting in 1968, at the Center for Studies of the Person. In more than two decades in California, Rogers wrote books on a person-centered approach to teaching and educational administration, on encounter groups, on marriage and other forms of partnership, and on the "quiet revolution" that he believed

would emerge with a new type of "self-empowered person." Rogers believed this revolution had the potential to change "the very nature of psychotherapy, marriage, education, administration, and politics" (Rogers, 1977). These books were based on observations and interpretations of hundreds of individual and group experiences.

A special interest of Rogers and his associates was the application of a person-centered approach to international conflict resolution. This resulted in trips to South Africa, Eastern Europe, and the Soviet Union, as well as in meetings with Irish Catholics and Protestants and with representatives of nations involved in Central American conflicts (Rogers & Ryback, 1984). In addition to Rogers's books, a number of valuable films and videotapes have provided data for research on the basic person-centered hypothesis that individuals and groups who have experienced empathy, congruence, and unconditional positive regard will go through a constructive process of self-directed change.

Current Status

Since 1982, there have been biennial international forums on the person-centered approach, meeting in Mexico, England, the United States, Brazil, the Netherlands, Greece, and South Africa. Alternating with these meetings have been international conferences on client-centered and experiential psychotherapy in Belgium, Scotland, Austria, Portugal, and the United States.

In September 1986, five months prior to his death, Rogers attended the inaugural meeting of the Association for the Development of the Person-Centered Approach (ADPCA) held at International House on the campus of the University of Chicago. At this meeting, which was to be the last Carl Rogers attended, the idea for a workshop on the person-centered approach was developed. The workshop, organized by Jerold Bozarth, Professor Emeritus at University of Georgia, and several graduate students, began a week after Carl Rogers's death on February 4, 1987. It was held in Warm Springs, Georgia, February 11–15, 1987, at the Rehabilitation Institute, where Franklin Roosevelt was treated after being struck by polio. Forty participants, including Barbara Brodley, Chuck Devonshire, Nat Raskin, David Spahn, and Fred Zimring, among others, came from Georgia, Florida, Illinois, Kansas, and Nevada. The group expressed its appreciation to Jerold Bozarth for allowing it to find its own direction and develop its own process. Workshops have been held annually at Warm Springs since 1987, and this nondirective climate has been maintained over the years. In addition to the Warm Springs Workshop, the ADPCA meets annually and can be accessed online at www.adpca.org. The association is composed of persons in many different occupations; educators, nurses, psychologists, artists, and business consultants are all part of this growing community of persons interested in the potential of the approach.

The *Person-Centered Review,* "an international journal of research, theory, and application," was initiated by David Cain in 1986. The journal has an editorial board made up of scholars and practitioners from around the world. In 1992, the *Review* was succeeded by the *Person-Centered Journal,* co-edited by Jerold Bozarth and Fred Zimring.

Raskin (1996) formulated significant steps in the evolution of the movement from individual therapy in 1940 to the concept of community in the 1990s.

In 2000, the World Association for Person-Centered and Experiential Psychotherapy and Counseling (WAPCEPC) was founded at the International Forum for the Person-Centered Approach in Portugal. This association consists of psychotherapists, researchers, and theorists from many countries and actively seeks to reassert the revolutionary nature of a person-centered approach. Association activities, conference schedules, and membership information may be found online at www.pce-world.org.

This organization has launched the peer-reviewed journal *Person-Centered and Experiential Psychotherapy* (PCEP), which publishes empirical, qualitative, and theoretical articles of broad interest to humanistic practitioners and researchers. Full-text articles are available online for the PCEP back to 2001. For a more thorough review of the current status of the person-centered approach, see Howard Kirschenbaum's and April Jourdan's (2005) article "The Current Status of Carl Rogers and the Person-Centered Approach."

PERSONALITY

Theory of Personality

Rogers moved from a lack of interest in psychological theory to the development of a rigorous 19-proposition "theory of therapy, personality, and interpersonal relationships" (Rogers, 1959b). On one level, this signified a change in Rogers's respect for theory. On another, this comprehensive formulation can be understood as a logical evolution. His belief in the importance of the child's conscious attitudes toward self and self-ideal was central to the test of personality adjustment he devised for children (Rogers, 1931). The portrayal of the client's growing through a process of reduced defensiveness and of self-directed expansion of self-awareness was described in a paper on the processes of therapy (Rogers, 1940). Rogers wrote here of a gradual recognition of a real self with its childish, aggressive, and ambivalent aspects, as well as more mature components. As data on personality changes in psychotherapy started to accumulate rapidly, with the objective analyses of verbatim interviews, Rogers found support for his belief that the facts are always friendly, despite some results that did not support his hypotheses.

Rogers expanded his observations into a theory of personality and behavior that he described in *Client-Centered Therapy* (1951). This theory is based on 19 basic propositions:

1. Every individual exists in a continually changing world of experience of which he or she is the center.
2. The organism reacts to the field as it is perceived. This perceptual field is, for the individual, "reality."
3. The organism reacts as an organized whole to this phenomenal field.
4. The organism has one basic tendency and striving—to actualize, maintain, and enhance the experiencing organism.
5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.
6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.
7. The best vantage point for understanding behavior is from the internal frame of reference of the individual.
8. A portion of the total perceptual field gradually becomes differentiated as the self.
9. As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed—an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with values attached to these concepts.

10. The values attached to experiences, and the values that are a part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.
11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, or (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self.
12. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of self.
13. Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual.
14. Psychological maladjustment 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. When this situation exists, there is a basis for potential psychological tension.
15. Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.
16. Any experience that is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.
17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and examined, and the structure of self revised to assimilate and include such experiences.
18. When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system, then he is necessarily more understanding of others and more accepting of others as separate individuals.
19. As the individual perceives and accepts into his self-structure more of his organismic experiences, he finds that he is replacing his present value system—based so largely on introjections that have been distortedly symbolized—with a continuing organismic valuing process. (pp. 481–533)

Rogers comments that

> This theory is basically phenomenological in character, and relies heavily upon the concept of the self as an explanatory construct. It pictures the end-point of personality development as being a basic congruence between the phenomenal field of experience and the conceptual structure of the self—a situation which, if achieved, would represent freedom from internal strain and anxiety, and freedom from potential strain; which would represent the maximum in realistically oriented adaptation; which would mean the establishment of an individualized value system having considerable identity with the value system of any other equally well-adjusted member of the human race. (1951, p. 532)

Further investigations of these propositions were conducted at the University of Chicago Counseling and Psychotherapy Research Center in the early 1950s in carefully designed and controlled studies. Stephenson's (1953) Q-sort technique was used

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to measure changes in self-concept and self-ideal during and following therapy and in a no-therapy control period. Many results confirmed Rogers's hypotheses; for example, a significant increase in congruence between self and ideal occurred during therapy, and changes in the perceived self resulted in better psychological adjustment (Rogers & Dymond, 1954).

Rogers's personality theory has been described as growth-oriented rather than developmental. Although this description is accurate, it does not acknowledge Rogers's sensitivity to the attitudes with which children are confronted, beginning in infancy:

> While I have been fascinated by the horizontal spread of the person-centered approach into so many areas of our life, others have been more interested in the vertical direction and are discovering the profound value of treating the infant, during the whole birth process, as a person who should be understood, whose communications should be treated with respect, who should be dealt with empathically. This is the new and stimulating contribution of Frederick Leboyer, a French obstetrician who . . . has assisted in the delivery of at least a thousand infants in what can only be called a person-centered way. (Rogers, 1977, p. 31)

Rogers goes on to describe the infant's extreme sensitivity to light and sound, the rawness of the skin, the fragility of the head, the struggle to breathe, and the like, along with the specific ways in which Leboyer has taught parents and professionals to provide a beginning life experience that is caring, loving, and respectful.

This sensitivity to children was further expressed in Rogers's explanation of his fourth proposition (The organism has one basic tendency and striving—to actualize, maintain, and enhance the experiencing organism):

> The whole process (of self-enhancement and growth) may be symbolized and illustrated by the child's learning to walk. The first steps involve struggle, and usually pain. Often it is true that the immediate reward involved in taking a few steps is in no way commensurate with the pain of falls and bumps. The child may, because of the pain, revert to crawling for a time. Yet the forward direction of growth is more powerful than the satisfactions of remaining infantile. Children will actualize themselves, in spite of the painful experiences of so doing. In the same way, they will become independent, responsible, self-governing, and socialized, in spite of the pain which is often involved in these steps. Even where they do not, because of a variety of circumstances, exhibit the growth, the tendency is still present. Given the opportunity for clear-cut choice between forward-moving and regressive behavior, the tendency will operate. (Rogers, 1951, pp. 490–491)

One of Rogers's hypotheses about personality (Proposition 8) was that a part of the developing infant's private world becomes recognized as "me," "I," or "myself." Rogers described infants, in the course of interacting with the environment, as building up concepts about themselves, about the environment, and about themselves in relation to the environment.

Rogers's next suppositions are crucial to his theory of how development may proceed either soundly or in the direction of maladjustment. He assumes that very young infants are involved in "direct organismic valuing," with very little or no uncertainty. They have experiences such as "I am cold, and I don't like it," or "I like being cuddled," which may occur even though they lack descriptive words or symbols for these organismic experiences. The principle in this natural process is that the infant positively values those experiences that are perceived as self-enhancing and places a negative value on those that threaten or do not maintain or enhance the self.

This situation changes once children begin to be evaluated by others (Holdstock & Rogers, 1983). The love they are given and the symbolization of themselves as lovable

children become dependent on behavior. To hit or to hate a baby sibling may result in the child's being told that he or she is bad and unlovable. The child, to preserve a positive self-concept, may distort experience.

> It is in this way . . . that parental attitudes are not only introjected, but . . . are experienced . . . in distorted fashion, *as if* based on the evidence of one's own sensory and visceral equipment. Thus, through distorted symbolization, expression of anger comes to be "experienced" as bad, even though the more accurate symbolization would be that the expression of anger is often experienced as satisfying or enhancing. . . . The "self" which is formed on this basis of distorting the sensory and visceral evidence to fit the already present structure acquires an organization and integration which the individual endeavors to preserve. (Rogers, 1951, pp. 500–501)

This type of interaction may sow the seeds of confusion about self, self-doubt, and disapproval of self, as well as reliance on the evaluation of others. Rogers indicated that these consequences may be avoided if the parent can accept the child's negative feelings and the child as a whole, while refusing to permit certain behaviors such as hitting the baby.

Variety of Concepts

Various terms and concepts appear in the presentation of Rogers's theory of personality and behavior that often have a unique and distinctive meaning in this orientation.

Experience

In Rogers's theory, the term *experience* refers to the private world of the individual. At any moment, some experience is conscious; for example, we feel the pressure of the keys against our fingers as we type. Some experiences may be difficult to bring into awareness, such as the idea "I am an aggressive person." People's actual awareness of their total experiential field may be limited, but each individual is the only one who can know it completely.

Reality

For psychological purposes, reality is basically the private world of individual perceptions, although for social purposes, reality consists of those perceptions that have a high degree of consensus among local communities of individuals. Two people will agree on the reality that a particular person is a politician. One sees her as a good woman who wants to help people and, on the basis of this reality, votes for her. The other person's reality is that the politician appropriates money to win favor, so this person votes against her. In therapy, changes in feelings and perceptions will result in changes in reality as perceived. This is particularly fundamental as the client is more and more able to accept "the self that I am now."

The Organism's Reacting as an Organized Whole

A person may be hungry but, because of a report to complete, skips lunch. In psychotherapy, clients often become clearer about what is important to them, resulting in behavioral changes directed toward the clarified goals. A politician may choose not to run for office because he decides that his family life is more important. A client with a disabling condition is more open to the changed circumstances of her life with the illness and is better able to care for herself in terms of rest and self-care.

The Organism's Actualizing Tendency

This is a central tenet in the writings of Kurt Goldstein, Hobart Mowrer, Harry Stack Sullivan, Karen Horney, and Andras Angyal, to name just a few. The child's painful struggle to learn to walk is an example. It is Rogers's belief and the belief of most other personality theorists that in the absence of external force, individuals prefer to be healthy rather than sick, to be free to choose rather than having choices made for them, and in general to further the optimal development of the total organism. Deci and Ryan's (1985, 1991) formulation of self-determination theory (SDT) has stimulated a number of recent empirical studies investigating situations that support or constrain intrinsic motivation, which is a natural feature of human living. Ryan and Deci describe this human capacity:

> Perhaps no single phenomenon reflects the positive potential of human nature as much as intrinsic motivation, the inherent tendency to seek out novelty and challenges, to extend and exercise one's capacities, to explore, and to learn. . . . [T]he evidence is now clear that the maintenance and enhancement of this inherent propensity requires supportive conditions, as it can be fairly readily disrupted by various non-supportive conditions. . . . [T]he study of conditions which facilitate versus undermine intrinsic motivation is an important first step in understanding sources of both alienation and liberation of the positive aspects of human nature. (Ryan & Deci, 2000, p. 70)

In Rogers's theory, the actualizing tendency functions as an axiom and is not subject to falsification. In the therapy situation, it is a functional construct for the therapist, who can conceive of the client as attempting to realize self and organism, especially when the client's behavior and ways of thinking appear self-destructive or irrational. In these situations, the client-centered therapist's trust in the client's self-righting, self-regulatory capacities may be sorely tested, but holding to the hypothesis of the actualizing tendency supports the therapist's efforts to understand and to maintain unconditionality toward the client. (Brodley, 1999c)

The Internal Frame of Reference

This is the perceptual field of the individual. It is the way the world appears to us from our own unique vantage point, given the whole continuum of learnings and experiences we have accumulated along with the meanings attached to experience and feelings. From the client-centered point of view, apprehending this internal frame provides the fullest understanding of why people behave as they do. It is to be distinguished from external judgments of behavior, attitudes, and personality.

The Self, Concept of Self, and Self-Structure

> These terms refer to the organized, consistent, conceptual gestalt composed of perceptions of the characteristics of the "I" or "me" and the perceptions of the relationships of the "I" or "me" to others and to various aspects of life, together with the values attached to these perceptions. It is a gestalt available to awareness although not necessarily in awareness. It is a fluid and changing process, but at any given moment it . . . is at least partially definable in operational terms. (Meador & Rogers, 1984, p. 158)

Symbolization

This is the process by which the individual becomes aware or conscious of an experience. There is a tendency to deny symbolization to experiences at variance with the concept of self; for example, people who think of themselves as truthful will tend to

resist the symbolization of an act of lying. Ambiguous experiences tend to be symbolized in ways that are consistent with self-concept. A speaker lacking in self-confidence may symbolize a silent audience as unimpressed, whereas one who is confident may symbolize such a group as attentive and interested.

Psychological Adjustment or Maladjustment

Congruence, or its absence, between an individual's sensory and visceral experiences and his or her concept of self defines whether a person is psychologically adjusted or maladjusted. A self-concept that includes elements of weakness and imperfection facilitates the symbolization of failure experiences. The need to deny or distort such experiences does not exist and therefore fosters a condition of psychological adjustment. If a person who has always seen herself as honest tells a white lie to her daughter, she may experience discomfort and vulnerability. For that moment there is incongruence between her self-concept and her behavior. Integration of the alien behavior—"I guess sometimes I take the easy way out and tell a lie"—may restore the person to congruence and free the person to consider whether she wants to change her behavior or her self-concept. A state of psychological adjustment means that the organism is open to his or her organismic experiencing as trustworthy and admissible to awareness.

Organismic Valuing Process

This is an ongoing process in which individuals freely rely on the evidence of their own senses for making value judgments. This is in contrast to a fixed system of introjected values characterized by "oughts" and "shoulds" and by what is supposed to be right or wrong. The organismic valuing process is consistent with the person-centered hypothesis of confidence in the individual and, even though established by each individual, makes for a highly responsible socialized system of values and behavior. The responsibility derives from people making choices on the basis of their direct, organismic processing of situations, in contrast to acting out of fear of what others may think of them or what others have taught them is "the way" to think and act.

The Fully Functioning Person

Rogers defined those who can readily assimilate organismic experiencing and who are capable of symbolizing these ongoing experiences in awareness as "fully functioning" persons, able to experience all of their feelings, afraid of none of them, allowing awareness to flow freely in and through their experiences. Seeman (1984) has been involved in a long-term research program to clarify and describe the qualities of such optimally functioning individuals. These empirical studies highlight the possession of a positive self-concept, greater physiological responsiveness, and an efficient use of the environment.

PSYCHOTHERAPY

Theory of Psychotherapy

Rogers's theory of therapeutic personality change posits that if the therapist experiences unconditional positive regard and empathic understanding of the client's communications from the viewpoint of the internal frame of reference of the client, and

succeeds in communicating these attitudes in the relationship with the client, then the client will respond with constructive changes in personality organization (Rogers, 1957, 1959b). Watson points out that

> If the client perceives the therapist as ungenuine, then the client will not perceive the therapist as communicating the other two conditions. It follows from this hypothesis that the client's perception of the therapist's congruence is one of the necessary and sufficient conditions for effective therapy. (Watson, 1984, p. 19)

When the core conditions are realized to some degree by the therapist (of any theoretical orientation), studies demonstrate that these qualities may be perceived by the client within the first several interviews. Changes in self-acceptance, immediacy of experiencing, directness of relating, and movement toward an internal locus of evaluation may occur in short-term intensive workshops or even in single interviews.

After a four-day workshop of psychologists, educators, and other professionals conducted by Rogers and R. C. Sanford in Moscow, participants reported their reactions. The following is a typical response:

> This is just two days after the experience and I am still a participant. I am a psychologist, not a psychotherapist. I have known Rogers's theory but this was a process in which we were personally involved. I didn't realize how it applied. I want to give several impressions. First was the effectiveness of this approach. It was a kind of process in which we all learned. Second, this process was moving, without a motor. Nobody had to lead it or guide it. It was a self-evolving process. It was like the Chekhov story where they were expectantly awaiting the piano player and the piano started playing itself. Third, I was impressed by the manner of Carl and Ruth [Sanford]. At first I felt they were passive. Then I realized it was the silence of understanding. Fourth, I want to mention the penetration of this process into my inner world. At first I was an observer, but then the approach disappeared altogether. I was not simply surrounded by this process, I was absorbed into it! It was a revelation to me. We started moving. I wasn't simply seeing people I had known for years, but their feelings. My fifth realization was my inability to control the flow of feelings, the flow of the process. My feelings tried to put on the clothes of my words. Sometimes people exploded; some even cried. It was a reconstruction of the system of perception. Finally, I want to remark on the high skill of Carl and Ruth, of their silences, their voices, their glances. It was always some response and they were responded to. It was a great phenomenon, a great experience. (Rogers, 1987, pp. 298–299)

This kind of experience speaks against the perception of the person-centered approach as safe, harmless, innocuous, and superficial. It is intended to be safe, but clearly it can also be powerful.

Empathic Understanding of the Client's Internal Frame of Reference

Empathic understanding in client-centered therapy is an active, immediate, continuous process with both cognitive and affective aspects. Raskin, in an oft-quoted paper written in 1947, describes this process.

> At this level, counselor participation becomes an active experiencing with the client of the feelings to which he gives expression, the counselor makes a maximum effort to get under the skin of the person with whom he is communicating, he tries to get within and to live the attitudes expressed instead of observing them, to catch every nuance of their changing nature; in a word, to absorb himself completely in the attitudes of the other. And in struggling to do this, there is simply no room for

> any other type of counselor activity or attitude; if he is attempting to live the attitudes of the other, he cannot be diagnosing them, he cannot be thinking of making the process go faster. Because he is another, and not the client, the understanding is not spontaneous but must be acquired, and this through the most intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention. (Raskin, 1947/2005, pp. 6–7)

The accuracy of the therapist's empathic understanding has often been emphasized, but more important is the therapist's interest in appreciating the world of the client and offering such understanding with the willingness to be corrected. This creates a process in which the therapist gets closer and closer to the client's meanings and feelings, developing an ever-deepening relationship based on respect for and understanding of the other person. Brodley (1994) has documented the high proportion (often as high as 80 to 90%) of "empathic understanding responses" in Rogers's therapy transcripts. Brodley's research has shown that Rogers's therapy was highly consistent throughout his career and did not waver from his trust in the client and his commitment to the principle of nondirectivity.

Unconditional Positive Regard

Other terms for this condition are warmth, acceptance, nonpossessive caring, and prizing.

> When the therapist is experiencing a positive, nonjudgmental, acceptant attitude toward whatever the client *is* at that moment, therapeutic movement or change is more likely. It involves the therapist's willingness for the client to *be* whatever immediate feeling is going on—confusion, resentment, fear, anger, courage, love, or pride. . . . When the therapist prizes the client in a total rather than a conditional way, forward movement is likely. (Rogers, 1986a, p. 198)

Congruence

Rogers regarded congruence as

> the most basic of the attitudinal conditions that foster therapeutic growth. [It] does not mean that the therapist burdens the client with all of his or her problems or feelings. It does not mean that the therapist blurts out impulsively any attitudes that come to mind. It does mean, however, that the therapist does not deny to himself or herself the feelings being experienced and that the therapist is willing to express and to be open about any persistent feelings that exist in the relationship. It means avoiding the temptation to hide behind a mask of professionalism. (Rogers & Sanford, 1985, p. 1379)

Relationship Therapeutic Conditions

There are three other conditions in addition to the "therapist-offered" conditions of empathy, congruence, and unconditional positive regard (Rogers, 1957).

1. The client and therapist must be in psychological contact.
2. The client must be experiencing some anxiety, vulnerability, or incongruence.
3. The client must perceive the conditions offered by the therapist.

Rogers described the first two as preconditions for therapy. The third, the reception by the client of the conditions offered by the therapist, is sometimes overlooked

but is essential. Research relating therapeutic outcome to empathy, congruence, and unconditional positive regard based on external judgments of these variables is supportive of the person-centered hypothesis. If the ratings are done by clients themselves, the relationship to outcome is stronger. Orlinsky and Howard (1978) reviewed 15 studies relating client perception of empathy to outcome and found that 12 supported the critical importance of perceived empathy. More recently, Orlinsky, Grawe, and Parks (1994), updating the original study by Orlinsky and Howard, summarized findings from 76 studies investigating the relationship between positive regard and therapist affirmation and outcome. Out of 154 findings from these studies, 56% showed the predicted positive relationship, and when patients' ratings were used, the figure rose to 65%. As Watson (1984) points out, the theory requires the client's perception of the attitudes, so in any outcome research, the client is the most legitimate judge of the therapist's attitudes (1984, p. 21).

Process of Psychotherapy

The practice of client-centered therapy is a distinctive practice by virtue of a thoroughgoing respect for the client as the architect of the therapy (Witty, 2004). This commitment differentiates client-centered therapy from psychoanalytic models and cognitive behavioral approaches that have *a priori* goals for the client. It distinguishes the approach from other humanistic therapies that involve directing the client to focus on particular experiences such as emotion-focused, focusing-oriented, and experiential orientations within the humanistic framework.

In the client-centered approach, therapy begins immediately, with the therapist trying to understand the client's world in whatever way the client wishes to share it. The first interview is not used to take a history, to arrive at a diagnosis, to determine whether the client is treatable, or to establish the length of treatment.

The therapist respects clients, allowing them to proceed in whatever way is comfortable for them, listening without prejudice and without a private agenda. The therapist is open to either positive or negative feelings, to either speech or silence. The first hour may be the first of hundreds or it may be the only one; this is for the client to determine. If the client has questions, the therapist tries to recognize and respond to whatever feelings are implicit in the questions. "How am I going to get out of this mess?" may be the expression of the feeling "My situation seems hopeless." The therapist will convey recognition and acceptance of this statement. If this question is actually a plea for suggestions, the therapist first clarifies the question. If the therapist has an answer, he or she will give it. Often, we may not really know an answer, in which case the therapist explains why. Either one simply doesn't know or doesn't yet have sufficient understanding to formulate an answer. There is a willingness to stay with the client in moments of confusion and despair. Reassurance and advice-giving are most often not helpful and may communicate a subtle lack of confidence in the client's own approach to his or her life difficulties. Brodley and other client-centered practitioners (1999a) agree that the attitude that leads the therapist to reassure and support the client is often a reflection of the therapist's own anxiety. There are no rules, however; in some cases, spontaneous reassurances may be given. It depends on the relationship and on the freedom and confidence of the therapist.

Principled nondirectiveness in practice requires that the therapist respond to the client's direct questions simply out of respect (Grant, 1990). In the case example later in this chapter, there are examples of the therapist responding directly to the client's questions. Learning to answer questions in ways that are consistent with nondirectiveness is an aspect of client-centered therapy as a discipline, since in everyday life, we are

often eager to assert our own frame of reference and readily jump in with answers. Brodley explains:

> The nondirective attitude in client-centered work implies that questions and requests should be respected as part of the client's rights in the relationship. These rights are the client's right to self-determination of his or her therapeutic content and process, and the client's right to direct the manner of the therapist's participation within the limits of the therapist's philosophy, ethics, and capabilities. The result of the therapist's respect towards these client rights is a collaborative relationship (see Natiello, 1994).
>
> This conception of the client's rights in the relationship is radically different from that of other clinical approaches. In other approaches, to a greater or lesser extent depending upon the theory, the therapist paternalistically decides whether or not it will be good for the client to have his or her questions answered or requests honored. The client-centered approach eschews decision making for the client. (Brodley, 1997, p. 24)

Regard is also demonstrated through discussion of options such as group therapy and family therapy, in contrast to therapists of other orientations who "put" the client in a group or make therapy conditional on involvement of the whole family. In this approach, the client is a vital partner in determining the nature of the therapy, the frequency, the length of time he or she wishes to invest in the work. On all issues pertaining to the client, the client is regarded as the best expert.

In a paper given at the first meeting of the American Academy of Psychotherapists in 1956, Rogers (1959a) presented "a client-centered view" of "the essence of psychotherapy." He conceptualized a "molecule" of personality change, hypothesizing that "therapy is made up of a series of such molecules, sometimes strung rather closely together, sometimes occurring at long intervals, always with periods of preparatory experiences in between" (p. 52). Rogers attributed four qualities to such a "moment of movement":

(1) It is something which occurs in this existential moment. It is not a *thinking* about something, it is an *experience* of something at this instant, in the relationship.

(2) It is an experiencing that is without barriers, or inhibitions, or holding back.

(3) The past "experience" has never been completely experienced.

(4) This experience has the quality of being acceptable and capable of being integrated with the self-concept.

Mechanisms of Psychotherapy

Broadly speaking, there are two theoretical perspectives that try to account for change in the person's concept of self that ultimately results in more effective functioning. The traditional paradigm, which is common to most psychotherapies, including client-centered therapy, asserts that change is the product of "unearthing" hidden or denied feelings or experiences that distort the concept of self, resulting in symptoms of vulnerability and anxiety.

In the course of development, most children learn that their worth is conditional on good behavior, moral or religious standards, academic or athletic performance, or undecipherable factors they can only guess at. In the most severe cases, the child's subjective reality is so consistently denied as having any importance to others that the child doubts the validity of his or her own perceptions and experiences. Rogers describes this process as "acquiring conditions of worth" and the resulting self as "incongruent." For persons whose own attempts at self-definition and self-regulation have met with

harsh conditions of worth, the act of voicing a preference or a feeling or an opinion is the first step in establishing selfhood and personal identity. From the perspective of the traditional theory, such a person has suppressed his or her own feelings and reactions habitually for long periods of time. The popularized image is one of a "murky swamp" of unexplored "forgotten" experiences.

There arises, however, the issue of how "feelings" that heretofore have been "hidden" or "not in awareness" exist as "entities." The traditional model has pictured these problematic feelings paradoxically as both existent (coming from the past) and yet nonexistent until symbolized in awareness (felt for the first time when expressed). This paradox requires resolution because logic demands it and because of the issue of where to direct our empathic understanding when we are listening to clients' narratives.

Fred Zimring, a colleague of Rogers, clarifies the problem: "If the therapist attends to material not in the client's awareness, the therapist is not in the client's internal frame of reference and so would not be fulfilling an important 'necessary' condition" (Zimring, 1995, p. 36). Additionally, how can we know what is not in the client's awareness until the client tells us? Zimring presents a new paradigm that unifies Rogers's theory of the necessary and sufficient conditions with the therapeutic practice of empathic understanding, which avoids the problematic notion of hidden or unknown feelings (1995). A much abbreviated version of his work is summarized here.

Zimring asserts that human beings become persons only through interaction with other persons and that this process takes place within a particular culture. If you were born into a Western culture, the notion of the "buried conflict" is part of your cultural legacy. There is some pathological entity "inside" that needs to be brought into the light of awareness. Whether it is the wounded "inner child" or "repressed memories" or one's "abandonment issues," the underlying assumption holds that until one is able to make the unconscious conscious, psychological maladjustment will persist.

By contrast, Zimring posits that each of us does, in fact, live within a phenomenological context akin to Rogers's notion of the inner frame of reference, but that that context is always "under construction." The self in this sense is a *perspective* that crystallizes and dissolves constantly in each moment of each new situation. It is a dynamic property arising from interactions between the person and the situation, rather than a static, private entity. Zimring explains:

> As mentioned above, the old paradigm assumes that our experience is determined by inner meanings and reactions. Thus, if we feel bad, it is assumed that we are not aware of some internal meaning which is affecting our experience. In the new paradigm our experience is seen as having a different source: experience is seen as coming from the context in which we are at the moment. We feel differently when in one context rather than in the other. (1995, p. 41)

Zimring explains that in the Western context, we tend to think in terms of an "inside" and an "outside." But actually we construct both the subjective, reflexive internal world and the objective, everyday world; that is, we interact with our own unique internal representations of both of these contexts. Persons differ in their awareness and access to the inner subjective context. This is understandable, given Rogers's explication of the ways in which the person's absorption of harsh conditions of worth tend to degrade or erase the significance of subjective experience. Zimring (1995) gives an example of a client he was working with who had little access to the subjective context at all:

> Most of the time these people see themselves as part of the objective world. When forced to describe something that may have subjective dimensions, they will emphasize the objective aspect of the thing described. A man described

> how he cried on the anniversary of his daughter's death. When asked how he felt when he was crying, he responded, "I hoped I could stop." In the client-centered situation, this person may be seen as the "difficult" client (the difficulty is not in the client but rather in the therapist's unrealistic expectation that the client "should" be talking about a subjective world). In other therapy contexts, this client is seen as defensive. The present analysis gives rise to a different description. Here, this client is seen as not having *developed* a reflexive, subjective world. (1995, p. 42)

Because, within the subjective context, "it is the quality of the reaction to which we are attending, its fresh presentness, personal relevance and aliveness" (Zimring, p. 41), we are, in that moment, free from the defining criteria of the objective context that is governed by logic, causation, success, or failure. Experience of the subjective context gives access to the inner locus of evaluation and the freedom from moralistic or pathologizing judgments (in the specific way Zimring is defining it). We can enter the objective context in our own inner representations, for instance, by picturing being blamed for losing a championship game by missing the last free throw and how we might deal with such a humiliating disappointment. But it is only when "I" attend to my feeling of disappointment with myself instead of reacting to the "me" that I can be said to have access to the subjective context and to allow the feeling to change.

Thus, Zimring is describing two different types of internal contexts: the objective context that is stressed in our culture as significant and meaningful, and the subjective context having little real-world value. Thinking of oneself as an object, as "me," is to inhabit an objective transactional state, whereas while thinking as a subject, as "I," is to inhabit a subjective transactional state. Client-centered therapists, by attending to and carefully attempting to understand the person's narrative (even though the narrative may be a story of what happened to the "me" at the basketball game), tacitly validate the subjective context, eventually strengthening the person's subjective context itself and access to it.

> The theory presented here assumes the self to be existing in the discourse that occurs in reaction to the phenomenological and social context, assumes a self that exists in perspective and in action, rather than a self that exists as an entity that determines action. This view of self implies a new view of the processes of change of self. This view is that the self changes from a change in perspective and discourse not from a discovery of the hidden, true self. . . . [T]he self changes, as feelings do, when we develop a new context. (1995, p. 47)

For some clients, establishing contact with their own subjective inner context within the facilitative interpersonal context of client-centered therapy may prove a difficult transition that may take time. Eventually, their access to that context and their ability to express it may increase. The self (the "I") that was available to the person only within therapy begins to appear in other contexts. An Asian American woman client of the third author recently said, "I was actually facing up to my father's anger. He was yelling at me that I was 'unfriendly,' meaning I wasn't doing what he wanted me to do. I could hardly recognize myself!"

It now is clearer why the client's perception of the therapist-provided conditions is so critical in achieving progress in therapy. Validation of the client's internal frame of reference (or, in Zimring's terms, the subjective context) is a serendipitous by-product of the process of interaction between the client who is communicating and the therapist's empathic responses. As the client perceives himself or herself as being received as unique and particular, as not being "made into an instance of anything else, be it a social

category, a psychological theory, a moral principle, or whatever" (Kitwood, 1990, p. 6), the person's experience of being a self is strengthened and changed. Zimring explains that empathic understanding allows the client to "change from being in the Me to being in the I state which also grows the I":

> [W]e are responding to the unique aspects of the person, to those aspects in which we are most individual. In responding to these, in checking with the person to see if our responses are valid, in our assumption that these unique aspects of the person are important truths, we are demonstrating our belief in the validity of the person's intentions and inner world. Once this happens, once people begin to believe in the validity of their intentions and inner world, of their internal frame of reference, they begin to respond from an internal rather than from an external frame of reference. When we see ourselves as I or agent rather than Me or object, our experience changes. (Zimring, 2000, p. 112)

Client-centered therapy, in common with other therapeutic approaches, aims to enhance the life functioning and self-experience of clients. Unlike other therapies, however, client-centered therapy does not use techniques, treatment planning, or goal setting to achieve these ends. Brodley states:

> It may seem strange, but the therapeutic benefits of client-centered work are serendipitous in the sense that they are not the result of the therapist's concrete intentions when he or she is present with or expressively communicating with the client. The absence of intentional goals pursued for clients seems to me to be essential for some of the therapeutic benefits of the approach. Specifically, the nondirectivity inherent in the therapist's expressive attitude helps protect the client's autonomy and self-determination. It has the effect of promoting the client's experience as the architect of the therapy. . . . Client-centeredness, in its nondirectivity and expressiveness—being profoundly nondiagnostic and concretely not a means to any ends—has an exceptional power to help without harming. (Brodley, 2000, pp. 137–138)

APPLICATIONS

Who Can We Help?

Since client-centered therapy is not *problem*-centered but *person*-centered, clients are not viewed as instances of diagnostic categories who come into therapy with "presenting problems" (Mearns, 2003). When the therapist meets the other person as a human being worthy of respect, it is the emergent collaborative relationship that heals, not applying the correct "intervention" to the "disorder" (Natiello, 2001). Of course, clients come to therapy for a reason, and often the reason involves "problems" of some kind. But the point is that problems are not assumed and are not viewed as instances of *a priori* categories. Mearns clarifies this stance:

> Each person has a unique "problem" and must be treated as unique. The definition of the problem is something the client does, gradually symbolizing different facets under the gentle facilitation of the therapist; the client's work in "defining the problem" *is* the therapy. This is the same reasoning behind Carl Rogers's statement that the therapy is the diagnosis. "In a very meaningful and accurate sense, therapy is diagnosis, and this diagnosis a process which goes on in the experience of the client, rather than in the intellect of the clinician." (Mearns, 2003, p. 90; Rogers, 1951, p. 223)

This philosophy of the person leads us in the direction of appreciating each person as a dynamic whole. Human lives are processes evolving toward complexity, differentiation, and more effective self/world creation. In contrast, the medical model sees persons in terms of "parts"—as problematic "conflicts," "self-defeating" behaviors, or "irrational cognitions." Proponents of client-centered therapy see problems, disorders, and diagnoses as constructs that are generated by processes of social and political influence in the domains of psychiatry, pharmaceuticals, and third-party payers as much as by *bona fide* science.

Another common misconception of client-centered therapy concerns the applicability of the approach. Critics from outside the humanistic therapies dismiss this approach as (1) biased toward white, Western, middle-class, verbal clients, and thus ineffective for clients of less privileged social class, clients of color, or those who live in collectivist cultures; (2) superficial, limited, and ineffective, particularly with "severe disorders" such as Axis II personality disorders; and (3) utilizing only the technique of "reflection" and thus failing to offer clients "treatments" of proven effectiveness. Students of this approach who wish to investigate both the critiques and the refutations are referred to several recent works: Bozarth's *Person-Centered Therapy: A Revolutionary Paradigm* (1998), Brian Levitt's *Embracing Non-directivity* (2005), and Moodley, Lago, and Talahite's *Carl Rogers Counsels a Black Client* (2004). In their analysis of Rogers's work with a black client, Mier and Witty defend the adequacy of the theory insofar as constructs such as experiencing and the client's internal frame of reference are held to apply universally. Tension or limitations in cross-cultural therapy dyads arise from the personal limitations and biases of the therapist (Mier & Witty, 2004, p. 104).

In therapy, some clients may define self fundamentally by their group identity—e.g., family or kinship relations, religion, or tribal customs. Many persons, at some points in their lives, may define themselves in terms of other types of group affiliation (e.g., "I am a transsexual," "I am a trauma survivor," "I'm a stay-at-home Mom"). These definitions of self tend to emerge in the therapy relationship and are accepted and understood as central to the client's personal identity. However, it is an error to suppose that client-centered therapists aim to *promote* autonomy, independence, or other Western social values such as individualism and self-reliance. Respect for and appreciation of clients precludes therapists' formulating goals. Consultation offers the opportunity for therapists to examine biases of all types and to progress toward greater openness and acceptance of clients' culture, religious values, and traditions.

Feminist scholars of therapy both within the humanistic tradition and from the psychodynamic traditions have criticized client-centered therapy as focusing only on the individual without educating the client to the political context of her problems. Although it is true that client-centered therapists do not have psychoeducational goals for clients, these writers fail to recognize the ways in which social and political perspectives emerge in client-centered relationships. The recent work of Wolter-Gustafson (2004) and Proctor and Napier (2004) shows the convergence between the client-centered approach and the more recent "relational" and feminist therapies.

In an interview with Baldwin shortly before his death in 1987, Rogers made the following statement that illustrates the consistency with which he endorsed the nondirective attitude: "[T]he goal has to be within myself, with the way I am. . . . [Therapy is effective] when the therapist's goals are limited to the process of therapy and not the outcome" (quoted in Baldwin, 1987, p. 47).

Occasionally, clients who are veterans of the mental health system may have incorporated clinical diagnoses into their self-concepts and may refer to themselves in those terms. For example, "I guess I suffer from major depression. My psychiatrist says I'm like a plane flying with only one engine." Even though client-centered therapists do not view clients through a diagnostic lens, this self-description is to be understood and

accepted, like any other aspect of the client's self-definition. It should be noted that this kind of self-categorization can be an instance of an external locus of evaluation in which a naïve and uncritical client has taken a stock label and applied it to himself or herself, or, conversely, it may represent a long, thoughtful assessment of one's experience and history, thus being a more truly independent self-assessment. If the client describes herself as "crazy" or "psychotic," the client-centered therapist would not say, "Oh, don't be so hard on yourself. You're not crazy." We put our confidence in the process of the therapy over time to yield more self-accepting and accurate self-appraisals on the part of the client, rather than telling the client how to think because his or her thinking is clearly wrong.

Although client-centered therapy is nondiagnostic in stance, client-centered therapists work with individuals diagnosed by others as psychotic, developmentally disabled, panic disordered, bulimic, and the like, as well as with people simply seeking a personal growth experience. This assumption that the therapy is generally applicable to anyone, regardless of diagnostic label, rests on the belief that the person is always more—that it is the person's expression of self and his or her relation between self and disorder, self and environment, that we seek to understand. Rogers states unequivocally that the diagnostic process is unnecessary and "for the most part, a colossal waste of time" (Kirschenbaum & Henderson 1989, pp. 231–232). Rogers elaborates on the issue:

> Probably no idea is so prevalent in clinical work today as that one works with neurotics in one way, with psychotics in another; that certain therapeutic conditions must be provided for compulsives, others for homosexuals, etc. . . . I advance the concept that the essential conditions of psychotherapy exist in a single configuration, even though the client or patient may use them very differently . . . [and that] it is [not] necessary for psychotherapy that the therapist have an accurate psychological diagnosis of the client. . . . [T]he more I have observed therapists . . . the more I am forced to the conclusion that such diagnostic knowledge is not essential to psychotherapy. (Kirschenbaum & Henderson, 1989, pp. 230–232)

When therapists do not try to dissuade clients from asking direct questions by suggesting that clients should work on finding their own answers, clients may occasionally request help from the therapist. Although there is some disagreement within the person-centered therapeutic community about answering questions, many client-centered therapists believe that following the client's self-direction logically requires responding to the client's direct questions. Depending on the question, such therapists might offer their thinking, which could include diagnostic observations, in the interest of providing the client with access to alternatives, including pharmacotherapy, behavioral interventions and the like. But, crucially, these offerings emerge from the client's initiative, and therapists have no stake in gaining "compliance" from the client with their offerings.

Client-centered therapists have worked successfully with a myriad of clients with problems in living, including those of psychogenic, biogenic, and sociogenic origins. The common thread is the need to understand the client's relationship to the problem, illness, or self-destructive behavior; to collaborate with the client in self-healing and growth; and to trust that the client has the resources to meet the challenges he or she faces. No school of psychotherapy can claim to cure schizophrenia or alcoholism or to extract someone from an abusive relationship. But within a partnership of respect and acceptance, the client's inner relation to the behavior or negative experience changes in the direction of greater self-acceptance and greater self-understanding, which often leads to more self-preserving behavior.

In spite of the stereotype of client-centered therapy as applicable only to "not-too-severe" clients, a number of client-centered scholars and practitioners have written

about the success of this approach with clients whose lives have been severely afflicted with "mental illness." For example, Garry Prouty's work with clients who are described as "psychotic" is described in his book *Theoretical Evolutions in Person-Centered/Experiential Therapy* (1994). Lisbeth Sommerbeck, a Danish clinician, in her book *The Client-Centered Therapist in Psychiatric Contexts: A Therapist's Guide to the Psychiatric Landscape and its Inhabitants,* presents the issues she deals with as a client-centered therapist in a psychiatric setting in which her colleagues treat "patients" from the traditional medical model (Sommerbeck, 2003).

In contrast to long-term therapy, the current trend with persons diagnosed with schizophrenia has focused on social skills training, occupational therapy, and medication. It is rare for such a person to experience the potency of a client-centered relationship in which she or he is not being prodded to "comply" with a medication regimen, to exhibit "appropriate" behavior and social skills, and to follow directives that are supposedly in the person's interest as defined by an expert. In the client-centered relationship, the person can express her or his own perceptions that the medication isn't helping, without the immediate response "But you know that if you stop the medication, you will end up back in the hospital." This respect of the person's inner experience and perceptions empowers the person as someone with authority about self and experience. This is not to deny the positive aspects of skills training, psychotropic medications, and psychiatry. If medications and programs really do help, clients can be trusted to *elect* to utilize them; if they are *forced* to do so by their families and therapists and by institutions of the state, they are being treated paternalistically, as less than fully capable of deciding their own course in life.

A case that stuck in Rogers's memory over the years was that of "James," part of the Wisconsin study of chronically mentally ill patients (Rogers et al., 1967). In the course of a detailed description of two interviews with this patient, a "moment of change" is described in which the patient's hard shell is broken by his perception of the therapist's warmth and caring, and he pours out his hurt and sorrow in anguished sobs. This breakthrough followed an intense effort by Rogers, in two interviews a week for the better part of a year, to reach this 28-year-old man, whose sessions were filled with prolonged silences of up to 20 minutes. Rogers stated, "We were relating as two . . . genuine persons. In the moments of real encounter the differences in education, in status, in degree of psychological disturbance, had no importance—we were two persons in a relationship" (Rogers et al., 1967, p. 411). Eight years later, this client telephoned Rogers and reported continued success on his job and general stability in his living situation, and he expressed appreciation for the therapeutic relationship with Rogers (Meador & Rogers, 1984).

This account emphasizes the person-centered rather than problem-centered nature of this approach. Rogers often stated his belief that what was most personal was the most universal. The client-centered approach respects the various ways in which people deal with fear of being unlovable, fear of taking risks, fear of change and loss and the myriad nature of problems in living. Understanding the range of differences among us, Rogers saw that people are deeply similar in our wish to be respected and loved, our hope for belonging, for being understood, and our search for coherence, value, and meaning in our lives.

Client-centered therapists are open to a whole range of adjunctive sources of help and provide information to clients about those resources if asked. These would include self-help groups, other types of therapy, exercise programs, medication, and the like, limited only by what the therapist knows about and believes to be effective and ethical. The attitude toward these psychoeducational procedures and treatments is not one of *urging* the client to seek out resources of any kind but, rather, to suggest them in a spirit of "you can try it and see what you think." The client is always the ultimate

arbiter of what is and what is not helpful and of which professionals and institutions are life-enhancing and which are disempowering.

Since the therapist is open to client initiatives, clients may at times wish to bring in a partner, spouse, child, or other person with whom they are having a conflict. Client-centered therapists are flexible and are often open to these alternative ways of working collaboratively with clients. The ethical commitment, however, is to the client, and it may be appropriate to refer others for couple or family therapy within the client-centered framework. A number of authors (including Nathaniel Raskin, Ferdinand van der Veen, Kathryn Moon and Susan Pildes, John McPherrin, Ned Gaylin, and Noriko Motomasa) have written about working with couples and families in the person-centered/client-centered approach.

This lack of concern with a person's "category" can be seen in person-centered cross-cultural and international conflict resolution. Empathy is provided in equal measure for Catholics and Protestants in Northern Ireland (Rogers & Ryback, 1984) and for black South Africans and whites in South Africa (Rogers, 1986b). Conflict resolution is fostered when the facilitator appreciates the attitudes and feelings of opposing parties, and then the stereotyping of one side by the other is broken down by the protagonists' achievement of empathy. Marshall Rosenberg, a student of Rogers at the University of Wisconsin, has developed an important approach to conflict that he calls "non-violent communication" (Rosenberg, 1999). This approach to communication implements the client-centered conditions in ways that do not dehumanize the other person or group.

Treatment

The person-centered approach has been described particularly in the context of individual psychotherapy with adults, its original domain. The broadening of the "client-centered" designation to "the person-centered approach" stemmed from the generalizability of client-centered principles to child, couple, and family work, the basic encounter group, organizational leadership, parenting, education, medicine, nursing, and forensic settings. The approach is applicable in any situation where the welfare and psychological growth of persons is a central aim. People who have institutional responsibility learn—often by trial and error—to implement the core conditions guided by the principle of nondirectiveness. For example, a graduate student in clinical psychology described going to the cell of an inmate he was seeing in therapy. He addressed the man as "Mr." and invited him to join him for the hour, giving him the power to refuse to talk if he didn't want to or feel up to it. This courteous treatment was such a contrast to the ways the man was treated by the prison guards that he wrote the student a long letter after the conclusion of the therapy, expressing his gratitude for being treated like a human being. Thus, even when clients are involuntarily mandated to "treatment," it is possible to function consistently from the core conditions.

Play Therapy

Rogers deeply admired Jessie Taft's play therapy with children at the Philadelphia Child Guidance Clinic, and he was specifically impressed by her ability to accept the negative feelings verbalized or acted out by the child, which eventually led to positive attitudes in the child. One of Rogers's graduate student associates, Virginia Axline, formulated play therapy as a comprehensive system of treatment for children. Axline shared Rogers's deep conviction about self-direction and self-actualization and, in addition, was passionate about helping fearful, inhibited, sometimes abused children develop the courage to express long-buried emotions and to experience the exhilaration of being themselves.

She used play when children could not overcome the obstacles to self-realization by words alone.

Axline made major contributions to research on play therapy, group therapy with children, schoolroom applications, and parent–teacher as well as teacher–administrator relationships. She also demonstrated the value of play therapy for poor readers, for clarifying the diagnosis of mental retardation in children, and for dealing with race conflicts in young children (Axline, 1947; Rogers, 1951).

Ellinwood and Raskin (1993) offer a comprehensive chapter on client-centered play therapy that starts with the principles formulated by Axline and shows how they have evolved into practice with parents and children. Empathy with children and adults, respect for their capacity for self-directed change, and the congruence of the therapist are emphasized and illustrated. More recently, Kathryn Moon has clarified the nondirective attitude in client-centered work with children (Moon, 2002).

Client-Centered Group Process

Beginning as a one-to-one method of counseling in the 1940s, client-centered principles were being employed in group therapy, classroom teaching, workshops, organizational development, and concepts of leadership less than 10 years later. Teaching, intensive groups, and peace and conflict resolution exemplify the spread of the principles that originated in counseling and psychotherapy.

Classroom Teaching

In Columbus, while Rogers was beginning to espouse the nondirective approach, he accepted the role of the expert who structured classes and graded students. At Chicago, he began to practice a new philosophy, which he later articulated in *Freedom to Learn:*

> I ceased to be a teacher. It wasn't easy. It happened rather gradually, but as I began to trust students, I found they did incredible things in their communication with each other, in their learning of content material in the course, in blossoming out as growing human beings. Most of all they gave me courage to be myself more freely, and this led to profound interaction. They told me their feelings, they raised questions I had never thought about. I began to sparkle with emerging ideas that were new and exciting to me, but also, I found, to them. I believe I passed some sort of crucial divide when I was able to begin a course with a statement something like this: "This course has the title 'Personality Theory' (or whatever). But what we do with this course is up to us. We can build it around the goals we want to achieve, within that very general area. We can conduct it the way we want to. We can decide mutually how we wish to handle these bugaboos of exams and grades. I have many resources on tap, and I can help you find others. I believe I am one of the resources, and I am available to you to the extent that you wish. But this is our class. So what do we want to make of it?" This kind of statement said in effect, "We are *free* to learn what we wish, *as* we wish." It made the whole climate of the classroom completely different. Though at the time I had never thought of phrasing it this way, I changed at that point from being *a teacher* and *evaluator,* to being *a facilitator of learning*—a very different occupation. (1983, p. 26)

The change was not easy for Rogers. Nor was it easy for students who were used to being led and who thus experienced the self-evaluation method of grading as strange and unwelcome.

The Intensive Group

The early 1960s witnessed another important development, the intensive group. Rogers's move to California in 1964 spurred his interest in intensive groups, and in 1970 he published a 15-step formulation of the development of the basic encounter group. Rogers visualized the core of the process, the "basic encounter," as occurring when an individual in the group responds with undivided empathy to another in the group who is sharing and also not holding back. Rogers conceptualized the leader's or facilitator's role in the group as exemplifying the same basic qualities as the individual therapist; in addition, he thought it important to accept and respect the group as a whole, as well as the individual members. An outstanding example of the basic encounter group can be seen in the film *Journey into Self,* which shows very clearly the genuineness, spontaneity, caring, and empathic behavior of co-facilitators Rogers and Richard Farson (McGaw, Farson, & Rogers, 1968).

Peace and Conflict Resolution

Searching for peaceful ways to resolve conflict between larger groups became the cutting edge of the person-centered movement in the 1980s. The scope of the person-centered movement's interest in this arena extends from interpersonal conflicts to conflicts between nations. In some instances, opposing groups have met in an intensive format with person-centered leadership. This has occurred with parties from Northern Ireland, South Africa, and Central America. A meeting in Austria on the "Central American Challenge" included a significant number of diplomats and other government officials (Rogers, 1986d). A major goal accomplished at this meeting was to provide a model of person-centered experiences for diplomats in the hope that they would be strengthened in future international meetings by an increased capacity to be empathic. Rogers (1987) and his associates also conducted workshops on the person-centered approach in Eastern Europe and the Soviet Union.

Rogers offered a person-centered interpretation of the Camp David Accords and a proposal for avoiding nuclear disaster (Rogers & Ryback, 1984). One notion is central to all these attempts at peaceful conflict resolution: When a group in conflict can receive and operate under conditions of empathy, genuineness, and caring, negative stereotypes of the opposition weaken and are replaced by personal, human feelings of relatedness (Raskin & Zucconi, 1984).

Evidence

Although clients almost never ask us to produce empirical evidence to support our claim that client-centered therapy will succeed in helping them, the question is entirely legitimate and one we should be capable of answering. To be a therapist is to represent oneself as a professional who is successful at helping. If one fails to help, there is an ethical responsibility to give the client an accounting for the failure (Brodley, 1974).

While the medical model of "treatment" is antithetical to client-centered philosophy and practice, objective, empirical research is not. Humanistic scholars see the links between theoretical models of therapy, research methods, and the practice of therapy as complex, plural, and not inevitable because they necessarily issue from differing philosophies of science and epistemologies. The fundamental question is posed: What is the relationship between scientific research findings and practice? What *should* the relationship be?

Support for Empiricism

Carl Rogers was a committed researcher and student of the therapy process, and he received the Distinguished Scientific Contribution Award from the American

Psychological Association in 1957. He said that it was the award he valued over all others. Client-centered scholars and researchers continue to be interested in finding answers to the questions of the efficacy and effectiveness of the client-centered approach. However, large-scale quantitatively focused studies have been lacking in recent decades, even though theoretical, philosophical, ethical, and naturalistic qualitative studies have burgeoned in the *Person-Centered Review* and *The Person-Centered Journal,* the *Person-Centered and Experiential Psychotherapy Journal,* and *Journal of Humanistic Psychology,* among many others, including non-English journals. Research in process-experiential therapy is an exception, as is the research being conducted in Germany (Eckert, Hoger & Schwab, 2003). Client-centered therapy also has strong support, albeit indirect support, from "common-factors" research efforts.

Common Factors

Saul Rosenzweig (1936) first hypothesized that outcome in psychotherapy might be due to factors that all therapies have in common (such as the personal characteristics of the therapist, the resources of the client, and the potency of the therapeutic relationship), rather than to techniques specific to theoretical orientations. This hypothesis was termed the *Dodo Bird conjecture.*

The character of the Dodo Bird appears in *Alice in Wonderland.* The animals decided to have a race to dry off after they were soaked by Alice's tears. Because they ran in all directions, the race had to be suspended. The animals appealed to the Dodo Bird for a decision. The Dodo Bird ruled as follows: "Everybody has won and all must have prizes!" The conclusion that all major psychotherapies, in fact, yield comparable effect sizes (measures of effectiveness) is often referred to as the *Dodo Bird effect.*

Decades of meta-analyses strongly support the Dodo Bird effect, refuting the idea that specific schools of therapy and their specific techniques are more important than the common factors (Elliott, 1996, 2002; Lambert, 2004; Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Wampold, 2006). Interestingly, even therapies that are based on radically different philosophies and values show similar effect sizes in terms of successful outcome in studies utilizing widely varying outcome measures.

The elements that constitute outcome can be categorized as either therapeutic or extratherapeutic. In the first category, we find effects that issue from the therapist, the therapeutic relationship, and the specific techniques associated with the particular therapeutic orientation. In the case of client-centered therapy, the therapist's experienced attitudes and communication of the attitudes, and the client's perception of these attitudes, are hypothesized to be the necessary and sufficient conditions that are causal factors leading to positive outcome. Therapeutic effects also include the impact of specific techniques that are sometimes utilized by nondirective client-centered therapists if clients suggest their use and if the therapist is competent in the particular technique. Lambert's 1992 study estimated that the variance in outcome attributed to therapeutic factors is approximately 30%; that attributed to techniques was about 15%. Placebo or expectancy effects represent 15% of the variance in outcome. (Client variables account for the remaining 40%.) This describes a situation in which the client has reason to expect that the therapy is going to make a positive difference in his or her life situation and experience simply by virtue of undertaking the therapy process with some degree of commitment.

Extratherapeutic factors include the environment of the client, the various vulnerabilities and problems he or she is dealing with, the presence or absence of adequate social support, and any particular events (such as losses or other changes) that influence the course of therapy. This category also includes client factors described by Bohart,

such as the person's own creative resources and ability to direct his or her decisions, resilience or hardiness, and life experience in solving problems in living and the client's own active utilization of the therapy experience (Bohart, 2006, pp. 223–234). This factor is estimated at 40% of the overall variance. Clearly, the client and the numerous variables that make up the internal and external realities of the client's situation contribute greatly to the therapy outcome equation (Bohart, 2004).[1]

If a client is not in therapy voluntarily, is hostile toward the process and the therapist, and is noncommittal about attending sessions, the likelihood of positive outcome diminishes. By contrast, a client who enters the relationship feeling a strong need to obtain help, who is open and willing to give therapy a try, who is consistent in following through in attending sessions, and who is capable of relating to the therapist is much more likely to benefit from the experience. This tradition of what is called common-factors research has yielded strong, very consistent findings supportive of the therapy relationship as a principal source of therapeutic change. Such research has also found that techniques, though not negligible, contribute much less to the actual outcome. Many clinicians, however, have resisted the common-factors position, insisting that their techniques are the difference which makes the difference.

Bozarth (2002), along with many others who support a contextual or common-factors position, opposes the idea that specific techniques (most often cognitive behavioral or other behavioral approaches) are crucial to therapeutic success. Further, he argues that this idea, which he calls the "specificity myth"—i.e., the belief that specific disorders require specific "treatments"—is a fiction. Bruce Wampold's (2001) book *The Great Psychotherapy Debate,* in which he reviews and reanalyzes many meta-analytic studies, supports Bozarth's assessment. Wampold concludes that the famous Dodo Bird verdict has been robustly and repeatedly confirmed. Wampold reiterates his findings in a more recent review (2006).

Despite the work of Wampold and others, resistance to the Dodo Bird verdict continues. New schools of thought and accompanying techniques produce income and status in the field of psychology, leading to a proliferation of "treatments" for an ongoing proliferation of "disorders" on which various practitioners announce themselves as experts. But in the big picture of psychotherapy outcome, the evidence strongly supports a contextual model of therapy in which, as Wampold points out, the specific ingredients are important only as aspects of the entire healing context (2001, p. 217).

Evidence for the Core Conditions

The client-centered approach can confidently claim evidentiary support for the core conditions and for the impact on outcome when the client's perception of the conditions is utilized as an outcome measure (this was part of Rogers's original hypothesis that the client must perceive the therapist-experienced conditions in order to derive benefit).

Truax and Mitchell's (1971) analysis of 14 studies with 992 total participants studied the association between the core conditions and outcome. Sixty-six significant findings correlated positively with outcome, and there was one significant negative correlation (Kirschenbaum & Jourdan, 2005, p. 41).

C. H. Patterson's "Empathy, Warmth and Genuineness: A Review of Reviews" (1984) critiques conclusions from many studies of the core conditions conducted in the 1970s and 1980s. Patterson concludes that in many studies in which client-centered therapy was either the experimental or the control condition, the therapists were not experienced

[1] Bohart argues that theories of therapy, including client-centered therapy, posit the therapist as the "engine of change," failing to credit the client's considerable capacities as a self-healer.

client-centered therapists. Researchers either knowingly or unknowingly equated client-centered therapy with active listening or simple repeating back what the client says, and, consequently, did not meet the requirements of the theory of the conditions necessary for change in psychotherapy. In spite of this, many studies produced positive results supporting the approach. Patterson speculates that the measures of outcome would probably have been substantially more significant had the therapists involved been committed to working from Rogers's premise and had developed their ability to realize the attitudinal conditions (Patterson, 1984). His review also notes the bias against client-centered therapy in many reviews, in spite of the actual positive evidence under review.

Orlinsky and Howard (1986) reviewed numerous studies focusing on relationship variables and clients' perception of the relationship. They found that generally between 50 and 80% of the substantial number of findings in this area were significantly positive, indicating that these dimensions were very consistently related to patient outcome. This was especially true when process measures were based on patients' observations of the therapeutic relationship. (Orlinsky & Howard, 1986, p. 365)

Orlinsky, Grawe, and Parks (1994), updating the original study by Orlinsky and Howard, summarized findings from 76 studies investigating the relationship between positive regard and therapist affirmation and outcome. Out of 154 findings from these studies, 56% showed the predicted positive relationship; when patients' ratings were used, the figure rose to 65%.

Bohart, Elliott, Greenberg, and Watson (2002) conducted a large meta-analytic study of empathy and outcome, surveying studies from 1961 through 2000. These studies involved 3,026 clients and yielded 190 associations between empathy and outcome. A medium effect size of .32 was found, which indicates a meaningful correlation. With regard to these last two studies, we must remember that studies of only one of the core conditions do not test Rogers's client-centered model of therapy; rather, all six of the necessary and sufficient conditions must be accounted for in the research design (Watson, 1984). Even so, positive correlations between outcome and empathy and between outcome and positive regard are partially supportive of the model.

A recent study by process-experiential researchers illustrates some of the difficulties in assessing client-centered therapy. Greenberg and Watson's (1998) study of experiential therapy for depression compares process-experiential interventions (in the context of the core conditions) to the client-centered relationship conditions. Basically, the study showed the equivalence of the relationship conditions with process-experiential interventions for depression. Although process-directivity received some support in long-term follow-up, the treatments did not differ at termination or at 6-month follow-up (Greenberg & Watson, 1998). Once again, however, because the "client-centered" experimental condition in this study was operationalized with a manual, the comparison condition does not represent client-centered therapy. Bohart comments about this particular study:

> It is true, in a sense, that client-centered therapy has been manualized (Greenberg and Watson, 1998). I have personally seen these manuals. They are very well done, but what they create is an excellent *analogue* of client-centered therapy mapped into a different intellectual universe. They do not fully represent client-centered therapy as I understand it. Again, the very concept of following a manual is antithetical to the basic nature of client-centered therapy. To manualize an approach like client-centered therapy reminds me a little bit of Cinderella's sister who tries to fit into the glass slipper by cutting off part of her foot. One can do it, and one can even make it fit, but would it not be better to find a scientific glass slipper that truly fits the phenomenon being studied instead of mangling it to fit it into one that doesn't? (Bohart, 2002, p. 266)

In pointing out the problems with studying client-centered therapy not as a treatment package but as a unique relationship, we are not denying the importance of finding adequate ways to conduct research on this approach (see Mearns & McLeod, 1984). Newer models are emerging from the humanistic research community that hold promise for more adequate assessments of this model, such as Elliott's single-case hermeneutic design, Bohart's adjudicational model, Rennie's studies of client experience while in the therapy hour, and many qualitative studies that have emerged in the past two decades.

Most recently, Elliott and Freire (2008; Elliott, 2002) conducted an expanded meta-analysis of humanistic therapies (including client-centered, process-experiential, focusing-oriented, and emotion-focused therapies) that assessed nearly 180 outcome studies. Their analyses examined 203 client samples from 191 studies, 14,000 people overall. Their findings follow.

1. Person-centered/experiential therapies are associated with large pre–post change. Average effect size was 1.01 standard deviations (considered a very large effect).
2. Posttherapy gains in person-centered therapies are stable; they are maintained over early (less than 12 months) and late (12 months) follow-ups.
3. In randomized clinical trials with untreated control clients, clients who participate in person-centered/experiential therapies generally show substantially more change than comparable untreated clients (controlled effect size of .78 standard deviations).
4. In randomized clinical trials with comparative treatment control clients, clients in humanistic therapies generally show amounts of change equivalent to clients in non-humanistic therapies, including CBT. (Elliott, 2002, pp. 71–72; Elliott & Freire, 2008).

Elliott and Freire conclude that their meta-analytic studies show strong support for person-centered/experiential therapy, even when compared to cognitive behavioral approaches. In some studies where CBT appears to have an edge over person-centered therapy, this advantage disappeared when they controlled for researcher allegiance (experimenter bias).

Evidence for the Self-Determining Client

The work of Ryan and Deci and colleagues supports the view of the person as intrinsically motivated toward autonomy, competence, and relatedness—that is, the active client as described by Bohart and Tallman (1999). The literature focusing on subjective well-being (SWB), hardiness and resilience, and self-determination and psychological well-being (PWB) supports the image of the active, generative, meaning-making person whom Rogers observed in his own therapy, which led him to postulate the actualizing tendency as the sole motive in human life.

Empirically Supported Treatments

In 1995, a Society of Clinical Psychology (Division 12) Task Force on Promotion and Dissemination of Psychological Procedures of the American Psychological Association (now known as the APA Division 12 Science and Practice Committee) was charged with identifying those "treatments" that warranted the description "empirically validated." This initiative followed on similar efforts in medicine to identify "best practices." The reasoning behind the effort to identify best practices for particular disorders such as bulimia, obsessive-compulsive disorder, depression, and generalized anxiety disorder, among others, seems straightforward. Are certain types of therapy more effective than others in helping people suffering with these problems? When this question and

its implications are explored in depth, however, many difficulties arise, and addressing them has led to greater clarity about the epistemological assumptions informing research studies.

The empirically supported treatments (EST) movement urges use of the "gold standard" research design utilized by pharmaceutical companies when testing the efficacy of new medications. This design calls for random sampling of subjects and random assignment to experimental and control groups using double-blind procedures so that neither the clinician nor the patient knows which group receives the active medication. Since double-blind procedures are not possible in testing therapeutic efficacy (because the therapist is aware of which is the "active" treatment), there is the immediate confound of researcher allegiance unless therapists committed to one orientation are compared to therapists equally committed to another.

Additional difficulties arise in deciding what the control will consist of and how it will be administered. Wampold (2001) argues that any control group must be a *bona fide* psychological treatment, not just a wait-list or group case management condition. Attrition from randomization is a common problem in randomized clinical trials (RCTs). Elliott (1998) has raised the issue of underpowered studies in which the numbers of subjects are too low to outweigh allegiance effects and other threats to validity.

As Wampold (2006) cautions, the fact that a "treatment" has not met the criteria to be labeled an empirically supported treatment does not mean that many therapeutic approaches are not just as effective as those treatments that have been studied using the Task Force's criteria. Wampold (2001) argues as follows:

> Simply stated, the conceptual basis of the EST movement is embedded in the medical model of psychotherapy and thus favors treatments more closely aligned with the medical model, such as behavioral and cognitive treatments. . . . As a result of this medical model bias, humanistic and dynamic treatments are at a distinct disadvantage, regardless of their effectiveness. . . . In the larger context . . . giving primacy to an EST ignores the scientific finding that all treatments studied appear to be uniformly beneficial as long as they are intended to be therapeutic. . . . Although apparently harmless, the EST movement has immense detrimental effects on the science and practice of psychotherapy, as it legitimates the medical model of psychotherapy when in fact treatments are equally effective. (pp. 215–216)

From the point of view of client-centered therapy research, the problem with many studies that focus on only one of the core conditions is that the client-centered model Rogers proposed is not being tested. Rogers proposed that the therapist-provided conditions/attitudes function holistically as a single gestalt, with the client perceiving the levels of the presence of the conditions in a succession of percepts and related inferences about the therapist's relation to her or him. Many studies of empathy, particularly those from other orientations, are, we believe, studying a somewhat different condition. A congruent, nondirective client-centered therapist who has no goals for the client, who is experiencing some level of positive regard, and who aims to empathically understand the communications of the client from within the frame of reference of the client is a different phenomenon from the therapist who deliberately sets out to establish a "therapeutic alliance" *in order to* establish bonds, tasks, and goals. Indeed, Rogerian therapy is a wholly different phenomenon from studies where "nondirective therapy" is used as a control in which the therapist uses empathic responses. These studies show nothing valid (pro or con) about true client-centered therapy. In spite of these methodological flaws and definitional differences, studies from a psychodynamic perspective also support the association between positive regard and outcome (Farber & Lane, 2002, p. 191).

Strong support exists for empathic understanding and positive regard, whereas the results of studies of congruence are more ambiguous. Part of the problem in studying congruence results from confusion about definitions. Many researchers, including person-centered investigators, seem to define congruence behaviorally as achieving transparency through self-disclosure. In fact, although Rogers advocated for client-centered therapists' freedom to be real and personal in the relationship, he didn't advocate saying whatever comes into one's mind. Only when the therapist has a "persistent feeling" should he or she consider raising the issue with the client. The necessity of maintaining the other core conditions influences how and when the therapist brings in his or her own frame of reference.

In research, congruence should be defined as an inner state of integration that naturally fluctuates throughout a session, in concert with the experienced attitudes of unconditional positive regard and empathy. The therapeutic attitudes combine into a gestalt as the therapist attends to the narrative of the client. Therapist congruence must be assessed primarily by the therapist; the client may evaluate whether he or she perceived the therapist as sincere, genuine, and transparent, but those evaluations are inferences based on the therapist's verbal and nonverbal behavior, not on congruence itself. Watson (1984) has argued that Rogers's 1957 hypothesis (which he intended to apply to all therapies) has not really been tested adequately. With some few exceptions, this is still the case more than two decades since Watson's meticulous examination of the data available on client-centered therapy in 1984.

Alternatives to the strategies of studying persons as objects, as the final repository of the action of independent variables, are humanistic research paradigms in which clients are co-investigators of the therapy process. Guidelines detailing these approaches can be found in a document produced by a Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services from the APA Division of Humanistic Psychology (2005; www.apa.org/divisions/div32/draft.html).

For a more comprehensive survey (from the humanistic side) of the issues involved in the EST controversy, see Bohart (2002); Elliott, Greenberg, and Lietaer (2004); Kirschenbaum and Jourdan (2005); Norcross, Beutler, and Levant (2006); Wampold (2006; 2001); and Westen, Novotny, and Thompson-Brenner (2004), among others. A recent book edited by Norcross, Beutler, and Levant, *Evidence-based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions* (2006), is a wide-ranging collection of articles debating the EST movement and challenging the RCT research model, as well as arguing for its continuing significance.

Psychotherapy in a Multicultural World

If the reader has followed Rogers's arguments against the "specificity hypothesis," it will come as no surprise to find that client-centered therapists have reacted with skepticism to arguments supporting the necessity of culture-specific approaches to each racial, cultural or ethnic group, gender identity, sexual orientation, or social class identity. Attempts to sensitize student therapists to cultural differences have often led to simplistic stereotypes about differing groups. We argue that within-group differences may exceed between-group differences, that groups' self-definitions are constantly under construction, and that similarly, group members are usually members of multiple groups leading to ever-increasing permutations of identity (Patterson, 1996).

A client-centered approach does not assume "difference" except as the client asserts how he or she experiences self as different. At the same time, those of us working from this approach understand that each person is completely unique in terms of

what his or her history, ethnicity, religion or lack of it, and racial identity(ies) mean. The task, as always, is empathic understanding of the client's communicated meanings about self and about the world he or she perceives and constructs.

Does this mean that client-centered therapy has a "one size fits all" approach? The answer is complex. We answer "yes" to the extent that *uniqueness of the person is a universal.* We answer "no" in order to counteract the prevalent color-blind assertion that "We're all human beings!" This seemingly benign assertion has masked many covert biases that therapists whose master statuses are dominant and "unmarked" have carried into therapy. The multicultural therapy movement has served to sensitize and challenge this kind of status quo thinking and practice. Client-centered therapists are just as prone to bias as therapists of differing theoretical orientations. We suspect that there is a qualitative difference in the empathic understanding process of the therapist who has been challenged on his or her biases and the therapist who is still denying them. Research has yet to be done regarding this contention, but it seems to us very likely that the quality and depth of empathy are affected by the therapist's own growth of understanding about his or her location in the various social hierarchies of dominance.

Our basic practice remains true to the core conditions no matter who our client may be. We also assert that our ability to form an initial therapeutic relationship depends upon our own openness to and appreciation of and respect for all kinds of difference.

CASE EXAMPLE

It has always been characteristic of the person-centered approach to illustrate its principles with verbatim accounts. This has the advantage of depicting the interaction between therapist and client exactly and gives readers the opportunity to agree or to differ with the interpretation of the data. The following interview took place in Szeged, Hungary, at a Cross-Cultural Workshop, in July of 1986. John Shlien, former colleague and student of Rogers, had convened a group to learn about client-centered therapy, and Dr. Barbara Temaner Brodley, who had practiced client-centered therapy for more than 30 years at that time, volunteered to do a demonstration interview. A young European woman who had recently earned a master's degree in the United States volunteered to be the client. There were several English-speaking participants in the observing group and 8 or 10 Hungarians. The Hungarian participants clustered together in a corner so as not to disturb the interview while they were receiving a simultaneous translation. The interview was scheduled for 20 minutes, more or less, depending on the client's wishes.

The Demonstration Interview[2]

Barbara: Before we start I'd like to relax a little bit. Is that all right with you? (Spoken to the Client) I would like to say to the group that I'm going to attempt to empathically understand my client, to do pure empathic following. As I have the need, I will express my empathic understanding of what she says, and expresses, to me about her concerns and herself. (Turns to Client) I want you to know that I am also willing to answer any questions that you might ask. (C: O.K.) If it happens that you have a question.

[2] Reproduced with permission from Fairhurst, I. (Ed). (1999). *Women writing in the person-centered approach,* Ross-on-Wye, UK: PCCS Books.

C1: You are my first woman therapist. Do you know that?
T1: I didn't know.
C2: And that's important for me because . . . uh . . . it sort of relates to what I'm going to talk about. Which has been going on in my mind since I decided to spend the summer in Europe. (T: Uhm-hm) Um . . . I spent the last two years in the United States studying, and (pause) when I left ******* in 1984, I was not the same person I am right now.
T2: Something has happened to you.
C3: A lot of things have happened to me! (laughs). And, I'm coming back to Europe this summer primarily to see my parents again. When I had left ******* two years ago, I had left in a state of panic. Promising almost never to go back. Promising never to see them again. And . . .
T3: Escaping and going *to* something.
C4: Yeah, yeah, yeah. Getting away from . . . and I had never expected that I would reach this point, that I would be able to go back and see them again.
T4: Uhm-hm. You were so sure, then.
C5: I was *angry*. (T: Uhm-hmm) I was *so angry*. And it's good for me that I'm taking all this time before I go back to *******. I mean this workshop now, and then I'm going to travel. And then I'm going to go to ******* at a certain point in August. (T: Uhm-hmm) But sometimes, I just, I'm struck by the fact that, *gosh,* I'm going to see them again, and how would that be? How will that be?
T5: You're making it gradual and yet at a certain point you will be there, (C: Uh-huh) and what will that be? (C: Uh-huh) Is? . . . you have, uh, an . . . anticipation or fear (C: Yeah) or (C: Yeah) something like that.
C6: Yeah, and I guess . . . I was thinking about my mother the other day, and . . . I realized, in the States, I realized that she and I had a very competitive relationship. And . . . it was interesting, but three days ago in Budapest I saw a lady in the street who reminded me of my mother. But my mother—not at the age which she has right now—but my mother 20 years from now. And, I don't know why. I was so struck by that because I saw my mother being old and, and, weak. So she was not this powerful, domineering person that she used to be in ******* who I was so much afraid of.
T6: Uhm-hm. But old and weakened and diminished . . .
C7: Diminished. That's the word. (T: Uhm-hm.) That's the word. (Begins to cry).
T7: It moved you to think of that, that she would (C: Yeah.) be so weak and diminished.
C8: And I think there was something in that lady's eyes that reminded me of my mother which (voice breaks; crying) I was not aware of when I was in *******. And it was fear. (T: Uh-huh) I saw fear in the woman's eyes. (T: Fear) Yeah. And, I was not aware of that.
T8: You mean, when you saw this woman who resembled your mother but 20 years from now, you saw in this woman's eyes something you had not realized was, in fact, in the eyes of your mother. (C: Yeah) And that was the quality of fear. And that had some great impact on you.
C9: Yeah. Because I felt that this woman needed me. (Crying) (Pause) It feels good that I am crying now. (T: Uhm-hm) I'm feeling very well that I am crying . . . (T: Uhm-hm)
T9: (Pause) It was a sense of your mother in the future, and that your mother *will* need you.
C10: You got it! The future stuff. It's not the present stuff. (Pause) It feels right here. (She places her hand over her abdomen.)

T10: The feeling is that your mother will have—has—fear and will have great need for you, (C: Yeah.) later on.

C11: Yeah. (Pause) And as I am going back to *******, I don't know if I'm ready to, if I'm ready to take care of her. I don't know if I'm ready to see that need expressed by her. (Continuing to cry)

T11: Uhm-hm, uhm-hm, uhm-hm. (Pause) You're afraid that when you get there, that will be more present in her. Or you will see it more than you did before, now that you've seen this woman. And that that will be a kind of demand on you, and you're afraid you're not ready to meet that.

C12: That's it, yeah, and it's gotten too much for me. Or, right now in Hungary, I perceive it as being too much. (Crying continues)

T12: Uhm-hm. At least, you're saying you're not sure how you will feel there, but it feels now like if that comes forth, if you see that, you, you, won't be able to . . . (C: Take it.) respond—be able to take it.

C13: Yeah, yeah. It was interesting. I kept looking at her, you know. And it's like I was staring at her and she was staring at me. She was Hungarian. She didn't know why I was looking at her and I didn't know why I was looking at her either. But it's like I wanted to take all of her in, and make her mine, and prepare myself. And suddenly I realized that all this anger I had was gone. There was nothing left. It was gone. (Crying)

T13: Uhm-hm. You mean, as you and this older woman looked at each other, and you had the meaning that it had for you about your mother, you wanted to—at that moment—you wanted to take her in and to give to her. To somehow have her feel that you were receiving her.

C14: Yeah. (Expressed with a note of reservation)

T14: The important thing is that . . . out of that you realized that you weren't afraid of your mother anymore, you weren't afraid of her dominance or . . .

C15: Yeah. Yeah.

T15: And that's a kind of incredible—(C: Discovery)—discovery and an incredible phenomenon that that (C: Yeah) fear and oppression could drop away so suddenly.

C16: And I guess, another feeling that I had also was, I felt sorry for her.

T16: Your mother.

C17: Yeah. (Pause) And I don't like feeling sorry for her at all. (Crying) I used to a lot. For a long time when I loved somebody I used to feel sorry for them at the same time. I couldn't split those two things. (Pause) I don't know what I'm trying to say right now . . . I don't know if I'm trying to say that I felt that I was loving her or that I was feeling sorry for her or both.

T17: There's a quality—pity . . . or feeling sorry for her that was strong but which you did not like. And then you don't know whether there was a quality of love that was part of that pity?

C18: Yeah.

T18: So both the feelings are mixed and confusing (C: Yeah) and then the reactions of—of having the sympathy and then having the (C: Uh-huh) pulling back (C: Uh-huh) from it.

C19: And I don't know if the woman did really resemble my mother or if it was my wish to make her resemble my mother. Maybe I'm ready (pause) ready to get there. I'm ready to see my mother as a person, and not—I can't put a word because I don't know how I was perceiving my life so far. But I had never perceived her as a woman in the street, just a woman, just another woman in the street, (her voice quakes with feeling) vulnerable and anxious and needy, and scared (softly).

T19: And you don't know whether you had changed and therefore saw—experienced this woman from the change, of being open to seeing all of that in your mother. (C: That's right) Or whether she really—when you looked at her—looked very much like your mother and how *she* would look. Is that right? (C: Yeah) You don't know which?

C20: Yeah.

T20: I guess then, that the really important thing is that you saw her, your mother, in your mind through this woman in a completely new way, as a person, as vulnerable, as afraid, as in need.

C21: Uhm-hm, uhm-hm. And that made me feel more human . . .

T21: Made *you* feel more human. (C: Uh-huh) To see *her* as more human (C: Also) made you feel more human in yourself.

C22: Yeah.

T22: Uhm-hm, because the force of how she *had* been to you—the tyrant or something . . .

C23: She had a lot of qualities. Some of them I don't remember anymore.

T23: But not a whole person to you, not a vulnerable person.

C24: Uhm-hm. (Pause) I said at the beginning that you were my first woman therapist. (T: Uhm-hm) I was avoiding women therapists like hell. (T: Uhm-hm) All the therapists I had were men so far and now I know why. I can't put why to words but I know why.

T24: That some of your feelings about *her* made you avoid a woman therapist and choose men?

C25: Yeah. (Pause) And lots of other things. But at this point, um, I, I'm perceiving everybody as another person, and that makes me feel more of a person as well.

T25: Uhm-hm. You're perceiving everybody (C: Everybody) as more rounded . . . um . . . (C: Yeah) including the therapist.

C26: Therapists were big—were a big thing for me for a long time. Very big authority figures and stuff like that. (T: Uhm-hm) So I guess I was afraid that a woman therapist—a woman therapist was very threatening to me. (T: Uhm-hm) Four years ago, three years ago. But at this point I feel everybody's a person.

T26: Everybody's a person. So that among the many transformations that have occurred since you left home (C: Yeah) for the United States. That's a big one. (C: That was . . .) That people have become persons to you instead of figures of various sorts.

C27: Absolutely true. I *mean* that's absolutely *right*. And it happened after I left *****.

T27: Uhm-hm.

C28: And I feel . . . (Looking toward group).

T28: And you feel it's about time?

C29: (Client nods.) Thank you.

T29: You're welcome. Thank *you*. (Client leans towards therapist and they embrace with affection and smiles.)

C30: Thank you very much. (They continue to embrace.)

Brodley comments about the interview:

> When I evaluate client-centered therapy interviews, I make a basic distinction between errors of understanding and errors of attitude. Errors of attitude occur when the therapist's intentions are other than maintaining congruence, unconditional positive regard and empathic understanding or other than a nondirective attitude. For example, when the therapist is distracted and failing to try to empathically understand the client. Or when the therapist is emotionally disturbed and unsettled.

Or when the therapist has lost unconditional acceptance and reveals this in the tone or content of his communications. Errors of understanding occur when the therapist is attempting to acceptantly and empathically understand, but misses or misinterprets what the client is getting at and trying to express. In this brief interview my volunteer client was in her mid-twenties and I was in my late fifties when the interview took place. It is impossible to know how much influence on the content of the interview resulted from my age being close to the client's mother's age. I do know that we had a good chemistry, were attracted to each other. The client and I had briefly encountered each other the evening before the interview and after the interview, she told me she had experienced a positive reaction to me (as I had toward her) and that she volunteered because I was to be the therapist. In the session I was emotionally open to her and felt strong feelings as she unfolded her narrative. One of our Hungarian observers told me after the interview, "now I understand client-centered therapy" because he saw tears in my eyes as I worked with her. (Brodley, 1999b; cited in Fairhurst, pp. 85–92)

Commentary

This interview illustrates, in concrete form, several principles of the process of client-centered therapy. The client's first statement, "You are my first woman therapist" precedes her direct question "Did you know that?" Barbara responds immediately, "I didn't know." Clearly, the client is implying that interacting with her first woman therapist is significant to her. Whereas some therapists might have immediately answered the question with another question, such as "Why is that significant?" client-centered therapists, in keeping with the nondirective attitude, do not prompt or lead their clients. The client here is free to pursue why it is significant or not to do so. She does say that Barbara's being a woman is important "because it sort of relates to what I'm going to talk about" but does not explain it more fully until later in the interview. And even then, she has a new awareness that she cannot really put into words. In C25, she states, "I said at the beginning that you were my first woman therapist. I was avoiding women therapists like hell. All the therapists I had were men so far and *now I know why*. I can't put why to words but I know why."

Commitment to nondirectiveness should not be understood as a tense, conscious inhibiting of what one might wish to say to a client. As therapists mature in the approach, the nondirective attitude is often described as involving an experience of relief. The therapist who has formerly felt responsible for the interaction trusts the client to decide how much to disclose and when to disclose it. In this interview, the client clearly directs the conversation toward a concern of great moment to her—the trip she will be making in a matter of weeks to see her parents, whom she had promised herself never to see again. She explains that she has been in the United States for the preceding 2 years as she studied for a master's degree and had not returned to her home country or her family. She explains that she had left home in a state of intense anger toward her parents—and now is wondering how it will be to see them after this absence that was more a voluntary exile than simply a peaceful time away.

During this part of the interview, the therapist makes several empathic following responses to check her understanding of the content of the story and also the client's immediate meaning. It is not until the therapist tentatively grasps the point of the client's narrative that it becomes possible to *experience empathic understanding*. In T5, the therapist says "You're making it [the return trip] gradual and yet at a certain point you will be there and what will that be . . . you have an anticipation or fear or something like that." This response is accepted, and the client moves on to tell of the encounter

she had 3 days ago in which her attention was captured by an older woman in the streets of Budapest. Although it is unclear to the client why she associated this older woman with her own mother, she reports being strongly affected by the spontaneous perception of her mother in the future as old and weak. "So she was not this powerful, domineering person that she used to be in [her country] who I was so much afraid of." The therapist's response in which she says "old and weakened and diminished" is an example of an accurate empathic response that exactly captures the client's immediate experiencing. This is an important difference between recounting an emotion (as the client had earlier when she recalled how angry she had been upon leaving her home and her parents) and the direct experiencing of the emotion. After the therapist's response, she replies, "diminished. That's the word. That's the word." At this moment she has access to deeply sensed though unidentified emotions.

Client-centered therapy, in this way, spontaneously stimulates the unfolding of the inner experiencing of the client. In experiential terms, the "felt sense" has been symbolized and is carried forward, allowing a new gestalt of experiencing to arise (Gendlin, 1961). But unlike process-directive and emotion-focused therapists' aims, the therapist was not aiming to produce focusing, nor was she trying to "deepen the felt sense" or to do anything except understand what the client was communicating. In this way, the powerful focusing effects that frequently occur in client-centered therapy are serendipitous and unintended. The stance of the nondirective therapist is expressive, not instrumental (Brodley, 2000). Barbara's use of the term *diminished* captures the client's perception of her mother in the future, and the client begins to weep.

As she moves further into the experience of her perception of the older woman, the client tells Barbara that what she saw in the woman's eyes was fear—a fear that she now realizes had been present in her own mother's eyes, although at the time she had seen it without being aware of having seen it, an instance of what Rogers has termed "subception." Barbara checks her understanding of this event, which occurred only days ago and involved a stranger in the present but someone who, for the client, represented her mother in the future, noting that the client's perception of fear in the woman's eyes "had some great impact on you." The client responds with immediacy and deep feeling: "Yeah, because I felt that this woman needed me" and she continues to cry. With her immediate experiencing openly available to her, she notes, "It feels good that I am crying now. I'm feeling very well that I am crying." A moment later she places her hand over her abdomen saying "it feels right here," letting the therapist know that she is having a direct, bodily awareness of her experiencing and that it feels good to her to allow herself to cry.

We infer that the therapist's embodiment of the therapeutic conditions has facilitated the deeply felt expression of this experience. It is also possible to infer, although we can't be sure, that the fact that the client has been to several male therapists indicates that Rogers's second condition (that the person be vulnerable and anxious) may apply to the client because of the risk she is taking to work with a woman for the first time, even though this is a single therapy session. She may be vulnerable regarding this experience, but she is actively seeking an opportunity for personal growth in the possibly intimidating setting of a public workshop.

Another way to look at this experience is in terms of its complexity. The client is feeling and expressing both sorrow and pity for her mother in the future and, at the same moment, is aware of a sense of well-being or fullness in the expression of the pain. Clients can be trusted to relate what is meaningful to them, moving toward the points they wish to bring out that embody meaning. At the same time as they are giving "content," they are experiencing themselves expressing meaning, and so there is a self-reflexive aspect of the communication that may remain implicit. In this instance, the client makes her relation to her own experiencing and expression explicit. The aim of empathic

understanding is not so much to catch the underlying, implicit feeling as much as to fully grasp both the narrative and the client's inner relation to what is being expressed. The agency or intentions of the person are to be understood simultaneously with the explicit content (Brodley, 2000; Zimring, 2000).

In the next part of the interview, the client reveals that as she stood looking at the Hungarian woman, and as she felt like taking the woman in and preparing herself, she recognized that her anger toward her parents had dissipated entirely. She says, "suddenly I realized that all this anger I had was gone. There was nothing left. It was gone." In this instance, she is recounting a powerful experience she had had a few days prior to the interview. And shortly she relates that she felt sorry for her mother in the midst of this perception—a feeling she did not welcome and one that, previously in her life, she had been unable to discriminate from love. In C20, there is what Rogers calls a moment of movement in which the client says, "I don't know if the woman did really resemble my mother or if it was my wish to make her resemble my mother. Maybe I'm ready . . . (pause) . . . ready to get there. I'm ready to see my mother as a person . . . I had never perceived her as a woman in the street, just a woman, just another woman in the street vulnerable and anxious and needy and scared."

The chance encounter with the Hungarian woman stimulated the client's recognition that her perception of her mother has shifted from someone she had resisted and feared and had seen as a figure of authority to someone whom she is perhaps ready to encounter as a human being who is "just a woman, just another woman in the street." The result of this shift is enhancing to her sense of herself as a person. In C26 she says, "But at this point, I'm perceiving everybody as another person, and *that makes me feel more of a person as well.*" One way to look at this interview is that there is movement from not being sure she is ready to see her mother's need to "maybe I'm ready . . . (pause) . . . ready to get there." It is possible that as she interacts with the therapist in this climate of acceptance and empathic understanding, she begins to feel more of her own strength and coping capacity.

Another aspect of this situation is the client's fear of women therapists, which is clearly related to her fear of and anger toward her mother. Again, it is possible that in her immediate interaction with a woman therapist onto whom she has projected negative feelings in the past, she experiences quite different emotions and reactions: the warm acceptance and presence of a real woman therapist. This allows a restoration of personal congruence in that we infer she is not reacting with anxiety and fear in the interview. This integrative experience may directly interact with the reorganization she experiences toward the feared mother from the past to the vulnerable, human mother in the future who will need her. Thus she may be experiencing a greater sense of autonomy; she is no longer in the grip of anger, and she is now ready or almost ready to encounter her mother as a vulnerable person. As Ryan and Deci point out, autonomy may be thought of in terms of volition as well as in terms of independence (Ryan & Deci, 2000, p. 74). The client's increasing sense of her freedom and her emerging sense of readiness to return leads to an increase in personal authority or power, as well as to an increased sense of her own humanity as someone who is at last perceiving other persons not as "figures" but simply as individual human beings. The client appears to have greater access to her own inner subjective context and, within the psychologically facilitative environment of the client-centered core conditions, to have become more of an authentic person in her own right.

When the client-centered therapy process persists over time, clients are likely to experience a deepening sense of self-authority and personal power. They become more capable of resistance to external authority, particularly when it is unjust, and more capable of deep connections with others. These changes in self-concept lead to more effective learning and problem solving and to enhanced openness to life.

SUMMARY

The central hypothesis of the person-centered approach postulates that individuals have within themselves vast resources for self-understanding and for altering their self-concepts, behavior, and attitudes toward others. These resources are mobilized and released in a definable, facilitative, psychological climate. Such a climate is created by a psychotherapist who is empathic, caring, and genuine.

Empathy, as practiced in the person-centered approach, consists of a consistent, unflagging appreciation for the experience of the client. It involves a continuous process of checking with the client to see whether understanding is complete and accurate. It is carried out in a manner that is personal, natural, and free-flowing; it is not a mechanical kind of reflection or mirroring. *Caring* is characterized by a profound respect for the individuality of the client and by nonpossessive, warm, acceptant caring or unconditional positive regard. *Genuineness* is marked by congruence between what the therapist feels and says and by the therapist's willingness to relate on a person-to-person basis, rather than through a professionally distant role.

The impetus given to psychotherapy research by the person-centered approach has resulted in substantial evidence demonstrating that changes in personality and behavior occur when a therapeutic climate is provided and utilized by an active, generative client. Two frequent results of successful client-centered therapy are increased self-esteem and greater openness to experience. Trust in the perceptions and the self-directive capacities of clients expanded client-centered therapy into a person-centered approach to education, group process, organizational development, and conflict resolution.

When Carl Rogers began his journey in 1940, psychotherapy was dominated by individuals who practiced in a manner that encouraged a view of themselves as experts. Rogers created a way of helping in which the therapist was a facilitator of a process that was directed by the client. More than half a century later, the person-centered approach remains unique in the magnitude of its trust in the client and in its unwavering commitment to the sovereignty of the human person.

ANNOTATED BIBLIOGRAPHY AND WEB RESOURCES

Barrett-Lennard, G. T. (1998). *Carl Rogers's helping system: Journey and substance.* London: Sage Publications.
A comprehensive and scholarly presentation of the person-centered approach to psychotherapy and human relations. It starts with the beginnings of client-centered therapy and the social–political–economic milieu of the 1920s and 1930s and continues with a description of early practice and theory, detailed examinations of the helping interview and the course of therapy, applications to work with children and families, and use with groups, education, conflict resolution and the building of community, and research and training. It concludes with a retrospective and prospective look at this system of helping.

Bozarth, J. (1998). *Person-centered therapy: A revolutionary paradigm.* Ross-on-Wye, UK: PCCS Books.
A collection of 20 revised and new papers by one of the movement's outstanding teachers and theoreticians. This book is divided into sections: Theory and Philosophy, The Basics of Practice, Applications of Practice, Research, and Implications. It reflects on Carl Rogers's theoretical foundations, emphasizes the revolutionary nature of these foundations, and offers extended frames for understanding this radical approach to therapy.

Raskin, N. J. (2004). *Contributions to client-centered therapy and the person-centered approach.* Ross-on-Wye, UK: PCCS Books.
This collection of Raskin's articles includes empirical studies, historical accounts of theoretical developments in the person-centered approach, and a personal description of Raskin's own growth as a person and therapist. It is a broad, incisively written compendium of articles by one of the founders of the approach.

Rogers, C. R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.
This book describes the orientation of the therapist, the therapeutic relationship as experienced by the client, and the process of therapy. It expands and develops the ideas expressed in the earlier book *Counseling and psychotherapy* (1942).

Rogers, C. R. (1961). *On becoming a person.* Boston: Houghton Mifflin.
Perhaps Rogers's best-known work, this book helped to make his personal style and positive philosophy known globally. The book includes an autobiographical chapter and sections on the helping relationship; the ways

in which people grow in therapy; the fully functioning person; the place of research; the implications of client-centered principles for education, family life, communication, and creativity; and the impact on the individual of the growing power of the behavioral sciences.

Rogers, C. R. (1980). *A way of being.* Boston: Houghton Mifflin.

As the book jacket states, this volume "encompasses the changes that have occurred in Dr. Rogers's life and thought during the decade of the seventies in much the same way *On becoming a person* covered an earlier period of his life. The style is direct, personal, clear—the style that attracted so many readers to the earlier book." In addition to important chapters on theory, there is a large personal section, including chapters on what it means to Rogers to listen and to be heard and one on his experience of growing as he becomes older (he was 78 when the book was published). An appendix contains a chronological bibliography of Rogers's publications from 1930 to 1980.

Web Sites

Association for the Person-Centered Approach (ADPCA), www.adpca.org

British Association for the Person-Centered Approach, www.bapca.co.uk

Center for the Studies of the Person, www.centerforthe person.org/

World Association for Person Centered & Experiential Psychotherapy & Counseling (WAPCEPC), www.pce-world.org

CASE READINGS

Ellis, J., & Zimring, F. (1994). Two therapists and a client. *Person-Centered Journal, 1*(2), 77–92.

This article contains the transcripts of short interviews by two therapists with the same client. Because 8 years intervened between the interviews, these typescripts permit a glimpse of the changes in the client over the period, as well as allowing for comparison of the style and effect of two client-centered therapists.

Knight, T. A. (2007). Showing clients the doors: Active problem-solving in person-centered psychotherapy. *Journal of Psychotherapy Integration, 17*(1), 111–124. [Reprinted in D. Wedding & R. J. Corsini (Eds.) (2011). *Case studies in psychotherapy* (6th ed.). Belmont, CA: Cengage.]

This case illustrates the ways in which a therapist can maintain a nondirective and person-centered approach while still responding to the expressed needs of clients who present with circumscribed problems they expect to solve.

Raskin, N. J. (1996). The case of Loretta: A psychiatric inpatient. In B. A. Farber, D. C. Brink, & P. M. Raskin, *The psychotherapy of Carl Rogers: Cases and commentary* (pp. 33–56). New York: Guilford.

This is one of the few verbatim recordings of a therapy interview with a psychotic patient, and it provides a concrete example of the application of client-centered therapy to a psychiatric inpatient diagnosed as paranoid schizophrenic. The interview shows a deeply disturbed individual responding positively to the therapist-offered conditions of empathy, congruence, and unconditional positive regard. It is especially dramatic because another patient can be heard screaming in the background while the interview is taking place.

Rogers, C. R. (1942). The case of Herbert Bryan. In C. R. Rogers, *Counseling and psychotherapy* (pp. 261–437). Boston: Houghton Mifflin.

This may be the first publication of a completely recorded and transcribed case of individual psychotherapy that illustrates the new nondirective approach. After each interview, Rogers provides a summary of the client's feelings and additional commentary.

Rogers, C. R. (1961). The case of Mrs. Oak. In C. Rogers, *On becoming a person.* Boston: Houghton Mifflin.

This classic case study documents a client's personal growth during a series of therapy sessions with Carl Rogers.

Rogers, C. R. (1967). A silent young man. In C. R. Rogers, G. T. Gendlin, D. V. Kiesler, & C. Truax (Eds.), *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics* (pp. 401–406). Madison: University of Wisconsin Press.

This case study consists of two transcribed interviews that were conducted by Rogers as part of a year-long treatment of a very withdrawn hospitalized schizophrenic patient who was part of a client-centered research project on client-centered therapy with a schizophrenic population.