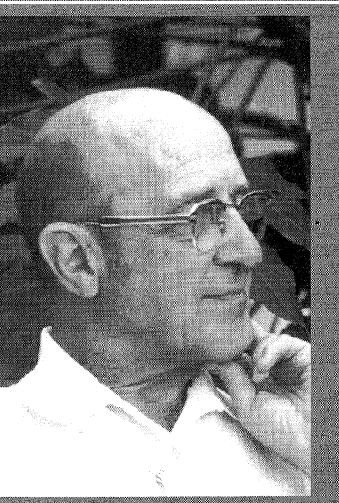

Carl R. Rogers, 1902–1987

5 CLIENT-CENTERED THERAPY

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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)

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> 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)

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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