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.