The Intensive Group

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

Peace and Conflict Resolution

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

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

Evidence

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

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

Support for Empiricism

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

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

Common Factors

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

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

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

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

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

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

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

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

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

Evidence for the Core Conditions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Evidence for the Self-Determining Client

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

Empirically Supported Treatments

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

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

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

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

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

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

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

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

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

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

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

Psychotherapy in a Multicultural World

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

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

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

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

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

CASE EXAMPLE

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

The Demonstration Interview[2]

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

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

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

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

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

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

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

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

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

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

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

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

C15: Yeah. Yeah.

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

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

T16: Your mother.

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

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

C18: Yeah.

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

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

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

C20: Yeah.

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

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

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

C22: Yeah.

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

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

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

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

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

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

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

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

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

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

T27: Uhm-hm.

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

T28: And you feel it's about time?

C29: (Client nods.) Thank you.

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

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

Brodley comments about the interview:

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

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

Commentary

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY

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

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

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

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

ANNOTATED BIBLIOGRAPHY AND WEB RESOURCES

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

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

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

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

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

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

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

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

Web Sites

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

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

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

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

CASE READINGS

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

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

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

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

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

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

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

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

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

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

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

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