

Carl Rogers

Client-Centred Therapy

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Rogers, Gendlin, Kiesler, Truax.

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Chapter One

The Conceptual Context

The Basic Concepts

As indicated earlier in this chapter, research in psychotherapy has been concerned with three major variables which are deemed to be important in any kind of change during psychotherapy. Listing them as problems, and putting them in the probable order of their occurrence, they are as follows:

1. What behaviors of the therapist are effective in initiating and maintaining change in the client or patient?
2. What behaviors of the client constitute the “process” of changing during psychotherapy?
3. What are the outcomes of this process?

In our research into the therapeutic relationship with schizophrenics and normals we were involved in all three of these issues. Some of the basic concepts which guided our work are described below.

Effective Therapist Behaviors

Our thinking in this area has been influenced by the developments in therapeutic thinking in general, but particularly by the evolution of client-centered therapy. The client-centered orientation was, at first, characterized by a rather specific technique or method: the therapist consistently responded by “reflecting” the client’s feeling. This meant that the therapist avoided diagnosis and deductions about the client, or interpretations of hidden meanings the client did not intend. Instead, the therapist attempted always to state in his own words what he sensed to be the client’s intended message, the client’s perception of his feelings, situation, difficulties, and the like. In this effort the therapist tried to sense not merely what was on the surface but the deeply felt meaning which the client only haltingly approached in what he said. Such responding, when successful, meant that the client’s own presently felt message was more deeply understood and responded to than he would have thought possible.

Gradually, the client-centered group noticed that the method was open to the pitfall of a rather wooden imitation, a sort of formula behind which a frightened or conflicted, or uninvolved, therapist could hide. The reflection formula of “You feel . . .” might look good on a transcript, but in action it could vary from a deep response to an artificial front. Seeman, Butler, Rogers, and others began to emphasize that not the technique but the

personal attitude, involvement, and the genuineness of empathy constituted effective therapist behaviors. (Similar trends toward realness and personal involvement were being emphasized in other therapy orientations during the same period.)

As mentioned earlier, Rogers formulated three attitudinal conditions which he held were “the necessary and sufficient conditions of therapy” (1957). Regardless of what method or technique the therapist uses, regardless of the Theoretical orientation he might hold, it was hypothesized that effective therapy would take place if the therapist fulfilled the following three “conditions”: (a) The therapist responds as the real person he actually is in this relationship at this moment. He employs no artificial front and does not have to hide or fear his real reactions. This condition was termed “congruence” (congruence between the therapist’s experiencing and his thoughts and behavior). (b) The therapist senses and expresses the client’s felt meaning, catching what the client communicates as it seems to the client. This condition was termed “empathy.” (c) The therapist experiences a warm and positive acceptance toward the client, a prizing of the client as a person whether the feelings and behaviors he is now exhibiting are regarded as valuable or as deplorable. This condition was termed “unconditional positive regard.”

These three “attitudes,” which are described much more fully in Chapter 6 on the therapeutic conditions antecedent to change, constitute one important cluster of variables which we have attempted to measure in this research. They are not, of course, as easy to measure as would be more clearly discernible verbal patterns such as interpretation, reflection, reassurance, suggestion. They were chosen as variables because theoretically they were deemed more significant than the simpler verbal patterns.

These “conditions” have certain novel aspects as research variables. In the first place they are intended to cut across the various schools of psychotherapy, and to apply to any type of psychotherapy. Since the various types of therapy appear to have a roughly similar incidence of success, it seems likely that the factors essential to success lie deeper than the different concepts and techniques of the various schools. The “conditions” are an attempt to define and measure these common underlying factors.

Secondly, the conditions pertain to underlying attitudes rather than to specific behaviors. Perhaps rather than the word “attitude” we should use some such term as “set.” We are not talking of a transitory something which could be expressed in one act or sentence of the therapist, but of a continuing “set” which consistently infuses all the different behaviors in which the therapist may engage. The conditions as defined emphasize that it is not *what* one does, but *how* one does it. It is not the verbal meaning but the personal meaning which is decisive. The conditions refer not so much to easily observable behaviors (asking, telling, ordering, rephrasing, interpreting, persuading, arguing) as to kinds of interpersonal qualities (realness, understanding, prizing). Measurement of these conditions involves the defining of objective behavioral indices which are relevant to and indicative of subjective modes of personal response.

Thirdly, this concept of conditions is unusual in its omission of diagnostic and theoretical conceptual apparatus...

... For this reason the concept is often somewhat baffling to those for whom

psychotherapy is primarily a cognitive venture, proceeding from a complicated theoretical structure. Though these attitudes of empathy, congruence, and unconditional positive regard are not easily acquired by the therapist, their learning is an experiential, rather than an intellectual matter. This has important implications.

There was one practical aspect of the use of such variables which we had not foreseen. Because they had to do with basic feelings of the therapist and not with his techniques, they imposed little or no restraint or self-consciousness upon the therapists in their dealing with their schizophrenic clients. Actually, as will be reported in more detail later, the therapists in our group found themselves trying out and developing many new and different modes of response behavior. The variety of specific behaviors among the therapists increased sharply. Even those therapists who were well aware of the therapist variables which would be studied felt very free to alter their mode of responding. If knowledge of these variables had any effect upon the therapist it was simply to focus more of his attention upon the feelings he was actually experiencing toward his client. The variables, because of their generality, remained applicable despite much variation in therapist behavior.

Client Behaviors Indicative of Ongoing Change

Turning now to the second major cluster of variables involved in our research, let us examine in a general way those elements of client behavior which seem to point to a process of change. The measurement of such behaviors is an important focus of the whole study.

On the basis of clinical observation, and after listening to many tape-recorded interviews, Rogers pointed out a number of behaviors which appeared to be characteristic of "movement" in therapy (1958). Gradually these behaviors have been incorporated into a theory of process, related to the theory of conditions described above. Briefly it may be said that as the client finds himself *prized*, in all the facets and aspects of himself which he is able to expose and express, he begins to prize himself, and to value his feelings and reactions. He commences to place more confidence in his own basic responses to situations. As the client finds himself *understood* by someone who seems to "stand in the client's place" in his understanding, he begins to take a more acceptantly understanding attitude toward his own reactions. He desires to know more of himself; he begins to regard the process of understanding his basic feelings as a worthwhile undertaking. As he recognizes the *realness* of the therapist, and the fact that the therapist is close to his own experiencing, able in the relationship to express and be his real feelings without fear, he (the client) is increasingly able to live in a closer relationship to *his* own experiencing, to what is going on within his own skin. He is able to express his feelings more accurately and with less fear. He discovers that his experiencing is a referent to which he may turn in guiding his behavior.

Thus, in response to the conditions the client has experienced in his relation to the therapist, he begins to show certain characteristic changes which will be spelled out in more detail in the chapters dealing with the measurement of process...

... He shows a change in the manner of his experiencing of his feelings, moving from a

remoteness from what is going on in his organism to an ability to experience feelings and personal meanings with immediacy. He changes in the way in which he construes experience, from rigid constructs which are thought of as fixed facts to a recognition that he is the creator of these constructs and that they are best held tentatively and are subject to checking. He changes in his manner of relating to his problems, from viewing them as entirely outside himself to accepting his own contributions to his problems and the degree of his responsibility for them. He changes in his manner of relating to others, from avoiding any close or expressive relationships to living openly and freely in such relationships.

As we worked from these observations and this tentative theory, various instruments were devised to measure this process quality of the client's behavior: a global scale, measuring the multiple indicators of movement; a scale of experiencing, focusing on the remoteness or immediacy of the client's relationship to his inner experiencing; a scale of problem expression, focusing on his manner of relating to his problems; a scale of personal constructs, focusing on his manner of construing experience; a scale of relationships, assessing the quality of the client's relationship to others; a scale of intrapersonal exploration focusing on the depth of the inner search achieved by the client in the therapeutic hour. These will be presented or discussed in their appropriate place.

It should be noted that these variables having to do with client behavior have certain novel features. First, like the variables having to do with therapist behavior, they refer to *how* rather than *what*. It is not a matter of *what* the client talks about (whether job difficulties, sex life, childhood experience, life anxieties, power drives, etc.) but of the *manner* of his expressive behavior, the manner in which he is *relating* to whatever content he is expressing. It is possible, for example, for a client to talk about material which is supposedly "deep," such as early sex experience, in a manner which shows that he is very remote from the experiencing of any feeling regarding it, and does not own the experiences as his own.

It is clear that these variables of client behavior are applicable to any mode of psychotherapy. It is evident in this theory that though clients in the various orientations may differ in the content material they are led to discuss, their manner of relating to what they are experiencing is expected to change in the fashion described.

These variables are defined in terms of the manner in which experiencing functions during psychotherapy. The basic theory of experiencing as defined by Gendlin (1962) is fundamental to the whole conception. It is this which gives meaning to descriptions such as those of the client's movement in therapy. At the lower end of the continuum of process the client is "very remote from his experiencing and unable to draw upon it or symbolize its implicit meaning. There is little expression about self and that is about self as an object." At the upper end of the continuum "in the moments of movement which occur ... there is a dissolving of personal constructs in a vivid experiencing of a feeling which runs counter to the constructs ... The self exits in the experiencing of feeling. At any given moment, the self *is* the experiencing." It is thus the experiential process in the client, rather than his concepts or words, which is central.

In spite of the above comments regarding the concept of process, it still may not be

clear as to the way in which the process of therapy is different from the outcome or final result of therapy. A word may be in order about the use of the term "process." In the experiential flow of events in a series of therapeutic interviews, certain characteristic sequences have been noted clinically. These may be thought of as evidence of therapeutic movement, of process, of the changing which is going on. Since research can never study flow itself, process becomes defined operationally as those discriminable characteristic sequences which are hypothesized to be indicative of different degrees of ongoing changing. Thus the individual may become more expressive of self-related feelings now than he was a month ago, or communicate less of non-self material, and more of self-description. Though such indicators of process are related to outcome, they come from a different order of discourse, representing points in a sequential flow of process events, rather than end points such as cure, recovery, or social adjustment, which are terms relating to outcome.

The reason for the focus of this investigation upon process is that the rewards seem much greater insofar as fundamental increase of knowledge is concerned. If we can understand the nature of the complex process of personality change, we will know much more than simply that a given procedure reaches a pre-selected end point in a certain percentage of cases. The study of process promises to lead to an accurate description of those behaviors which in fact indicate that psychotherapy is going on in the client. Thus we can look forward to the time when we will be able to determine, with some degree of exactness, whether therapy is or is not occurring.

A final comment about this cluster of variables is that they seem to be close to what has been regarded in differing orientations as essential to therapeutic movement. It is generally recognized that psychotherapy is a highly subjective, experiential process. Alexander (1948) has called it "emotional learning." Freud (1936, 1959) pointed out that interpretations and their acceptance are only the start. The "part of the work that effects the greatest changes in the patient" is "working through." Whitaker and Malone (1953) speak of a conversation of two unconsciousnesses, and they contrast this with "intellectual verbiage." The important contrast between "intellectualizing" and "defensive verbalizations," on the one hand, and "really being engaged in therapy," on the other hand, has long been recognized (Gendlin, 1964). In short, it is widely agreed that effective psychotherapy is, for the client, a deeply felt, concrete, emotional, experiential process, and that only through such an experience does change occur. The mere words or concepts can be sophisticated and correct, yet change does not occur through these alone. It is, therefore, of considerable significance to make the attempt to measure the observable behaviors in which the client engages when this experiential process occurs.

A Concept of Outcomes

In the initial planning of the research it was the aim to build our investigation almost entirely around the concepts of the "therapeutic conditions" in the relationship and the "process movement" in the client. By the time we were ready to draw up the actual research design, it was evident that it would be unwise to base the whole study on measures which were new - for the conditions measures had not been used on schizophrenics, and the process measures had been little used on any population...

... Consequently we felt the need to use some of the more generally acceptable criteria

of outcome, even though we were well aware of their shortcomings. We needed such criteria in order to show what relationship existed, if any, between measures of the therapist factors and outcome, and between measures of the client's process and outcome. We also needed such outcome measures to communicate to the clinical worker who is more accustomed to thinking in terms of results rather than in terms of process.

As a consequence of this thinking, the research program made use of some of the more traditional diagnostic instruments, given at the start of therapy and at its conclusion. Initially we had hoped to be able to repeat these measures every six months during therapy in order to have measures of continuing change which would be directly comparable for every person in the study, but this aim proved impossibly ambitious, and could not be fully carried through. We were able, however, to obtain to early and late or before and after measures for this purpose.

The tests which were used included, among others, the Rorschach, the Thematic Apperception Test, the Minnesota Multiphasic Personality Inventory, a Q-sort for self-perception, the Wechsler Adult Intelligence Scale, and an anxiety measure compiled by Charles Truax.

There are difficulties involved in the use of these instruments as measures of change. First of all, in most instances they are designed to diagnose relatively permanent personality characteristics rather than characteristics of change. Thus Schactel, in a personal communication emphasizes that recovered schizophrenics and adequately functioning relatives of schizophrenics give Rorschach responses and patterns like those of schizophrenics. In other words, the test has tapped personality characteristics which seem not to change even when the person changes markedly in his social functioning. Similarly, the MMPI is made up in rather large measure of items phrased in the past tense such as "I have had very peculiar and strange experiences," and "I have had periods in which I carried on activities without knowing later what I had been doing." Once such statements are true for a person they would hardly be expected to change, even though the individual might have changed markedly in therapy. So although such instruments have often been used in studies of outcomes in therapy, they are actually decidedly deficient as measures of change.

Another difficulty is that for most of these tests there are various methods of analysis, and the choice of method is difficult. For example, in one research investigation two TAT experts analyzed "blind" the TAT tests given before and after therapy. Neither analyst knew which TAT came from a more successful case and which from a less successful. Using different modes of approach to the data, one analyst found the successful cases significantly improved, the other found them significantly regressed.

In an attempt to supplement such personality measures, ratings on hospital behavior were decided upon, to be obtained from hospital staff members. Such measures are also open to many serious criticisms, but at least they approached the issue of outcomes from a different perspective. Records were also kept of the length of hospitalisation for each individual involved in the research.

The description of these deficiencies in the various types of instruments is sufficient to

indicate why we did not wish to make such outcome measures the base of our study. Nonetheless we chose, for the reasons indicated earlier in this section, to make a broad approach to this problem. Our concept of outcome was an inclusive one, and measures of perception of personality change by a diagnostician, measures of personality change as self-perceived, measures of change in behavior and social adjustment, were all included. It was believed that these measures could be combined for a global indicator of degree of change, or could be used separately and related to various aspects of the measures of relationship and process. These measures are also helpful in assessing post-therapy behavior, being relatively free of the contamination of bias which is almost inevitable in the usual follow-up report of the individual's adjustment after therapy.

The Hypotheses

The central hypotheses of the study were formulated before the design was developed. These hypotheses were intended to explore the relationships between the three major concepts, outlined above, regarding therapy. They will be stated here briefly, and should be recognized as I have the heart and core of the research.

The First Hypothesis

It was hypothesized that *the greater the degree to which the conditions of therapy exist in the relationship, the greater will be the evidences of therapeutic process or movement in the client.*

This hypothesis builds on the concept that effective therapist behavior is constituted of the three attitudinal sets discussed earlier in this chapter - the realness, empathy, and unconditional positive regard of the therapist. The hypothesis states that a higher degree of these conditions - singly or in combination - will be antecedent to a higher degree of those client behaviors characteristic of movement in therapy.

The Second Hypothesis

This hypothesis was worded in different ways. Its first wording was: Given equivalent conditions of therapy, the therapeutic process or movement will be the same in the chronic schizophrenic, the acute schizophrenic, and the well-adjusted normal person. Somewhat later it was worded in a more practicable form: *The same variables of process movement will characterize the in-therapy behavior of more acute schizophrenics, more chronic schizophrenics, normals, and neurotics.*

It may surprise experienced therapists that we expected the process of therapy to be the same for these different groups, ranging from chronic schizophrenics to normals. Our essential interest in this hypothesis lay in the theoretical conviction that the process of constructive personality change would be basically similar no matter what the diagnosis or personality type of the individual involved. It was recognized that many therapists hold a sharply different view. For this reason it seemed important to test this conception.