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PERSON-CENTERED PSYCHOTHERAPY: ONE NATION, MANY TRIBES

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Many people have noted that after the death of a great leader, groups of people following that person's teaching tend to go through a sustained period of turmoil, conflict, and self-doubt. Certainly, Carl Rogers would not have wanted to be considered as a messianic leader whose personal definitions and beliefs should be followed in any unquestioning or doctrinaire way. Indeed, his belief in the value of the self-direction of each individual person was so strong that he once went so far as to declare that he himself was not a "Rogerian." On the surface it would seem that followers of Rogers would be freed from the need to determine who is "really" Rogerian, or client-centered, or person-centered.[1]

Still, therapists who ground their work and their lives in Rogers' teachings have experienced considerable stress in their efforts at self-definition and organization in the ten years since Rogers' death. Therapists disagree passionately as to what is really "client-centered" or "person-centered" and whether the two are the same. Some would include almost all therapies that have some emphasis on genuineness or empathy as client-centered. Others would define the term client-centered therapy very narrowly, in ways that would limit its application to a much smaller group of practitioners--those who follow the high levels of nondirectivity evident in taped versions of Rogers' psychotherapy practice. Much as client-centered therapists might have hoped that their philosophy of respect for individual difference would avoid power struggles and intense debates over issues of definition, we seem to have to deal with these issues much as would any other therapeutic movement.

In this paper, I will make a personal attempt to lay out the issues as I see them and to make a case for a set of criteria to distinguish between person-centered and other therapies. These criteria fall somewhat in between the most narrow and the most broad possibilities suggested by current literature on client-centered therapy. I will make the case that person-centered therapy should not be considered a single form of psychotherapy, but rather a cluster of therapies sharing some broad values. These therapies are distinct enough that it makes sense for them to develop separate organizations and journals and training programs. However, I suggest that they have enough in common that it makes theoretical and pragmatic

sense for them to maintain a joint identity under a broad person-centered umbrella. To do this, I will first review Rogers' own statements related to the definition of client-centered (and person-centered) psychotherapy, and then consider the choices about core definitions that emerge.

Rogers consistently presented six conditions as necessary and sufficient for therapeutic change. In his landmark "Necessary and Sufficient Conditions for Therapeutic Personality Change" (1957) paper, he presented these conditions as follows:

1. Two persons are in psychological contact.

2. The first person, whom we shall call the client, is in a state of incongruence, being vulnerable or anxious.

3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.

4. The therapist experiences unconditional positive regard for the client.

5. The therapist experiences an empathic understanding of the client's internal frame of reference, and endeavors to communicate this experience to the client.[2]

6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1957)

The overwhelming majority of Rogers' own responses, as available in recorded psychotherapy sessions, consist of attempts to communicate and/or check his understanding of the client's experience from the client's own frame of reference. Very small numbers of responses could be seen as attempts to direct clients' attention to certain aspects of their communication. Occasionally Rogers makes comments from his own frame of reference, but these tend to be very close to the client's own material and are often in response to specific client questions or requests (Brodley, 1991, 1996; Brodley & Brody, 1990). Rogers' own practice, then, seems to follow a highly nondirective style of psychotherapy. And, at some early points in his writings he discusses the therapist's attitude of nondirectivity as being central to a client-centered way of working (Rogers, 1951).

Yet, in his theoretical writings, Rogers commented several times that virtually any sort of technique or intervention might serve to convey the therapist's empathy, congruence and unconditional positive regard. In his classic 1957 paper, "The Necessary and Sufficient Conditions of Therapeutic Personality Change", he notes that: "...the techniques of various therapies are relatively unimportant except to the extent to which they serve as channels for fulfilling one of the conditions." Similarly, in "The Characteristics of a Helping Relationship" he says that: "it is the attitudes and feelings of the therapist, rather than his theoretical orientation, which is important. His procedures and techniques are less important than his attitudes."

These statements seem to imply that virtually any therapy, however outwardly interpretive, might be considered "client-centered" if interventions are authentic and perceived by the client as conveying empathy and prizing. Rogers may, of course, be talking more generally about therapy in these instances rather than "client-centered" therapy in particular. (See, for example, J. Bozarth, 1996.) If so, he does not make a point of drawing a distinct line between "client-centered" therapy and other therapies grounded in the core conditions. This degree of unclarity is particularly notable in comparison to his clearness and consistency on other issues. For example, Rogers leaves no doubt in any reader's mind about the strength of his belief that empathy, congruence and unconditional positive regard are essential to effective therapy.

I suspect that this discrepancy between the restraint of Rogers' own practice and his general reluctance to offer precise guidelines for other client-centered practitioners arose because he felt committed to the self-direction of all people-- therapists as well as clients. His concern for client self-direction led him to stay extremely close to clients' explicit wishes and spontaneously emerging process. Yet he showed little inclination to specify how other therapists should practice. He seems to be saying to therapists, as he said to his client Gloria, "It's no damn good if you're doing something you haven't really chosen to do" (Farber, Brink, & Raskin, 1996, p. 62).

The ambiguity in Rogers' own statements has led client-centered theorists to take widely varying positions on the centrality of nondirectivity to client-centered practice (White, 1997). Some, following Rogers' broader statements would see Rogers as defining qualities which many therapists would see as essential to all good therapy (Bozarth, 1996; Van Kalmthout & Pelgrim, 1990). In a 1990 paper, Bozarth notes that:(therapists) must achieve first and foremost their own congruence. This congruence going beyond their own experiencing with their behaviors may include their own "technique system" maximizing their capacity for the experiencing of the core conditions" (p. 32).

Other person-centered practitioners would tend to judge the value of statements coming from outside the client's frame of reference by particular, carefully specified criteria. Such therapist responses are often seen as most consistent with person-centered values when they focus on process rather than content, when they are framed in ways that encourage the client decide the value of particular suggestions for him or herself, and when they occur relatively infrequently.[3] Germaine Lietaer (1990, p. 33), for example, comments: "As "process experts", [client-centered therapists] have found ways to intervene actively without falling into authoritarian control. The central principle here is that the experience of the client has to remain the touchstone for what is introduced by the therapist."

Other person-centered theorists suggest that any systematic rationale for therapist responding which comes from outside the client's frame of reference contradicts an attitude of nondirectivity that is central to client-centered work (Brodley, 1990; Raskin, 1947). Brodley (1990) declares that:

> In practice, with rare exceptions, the client-centered therapist, guided by his non-directive attitude, has no directive intentions in relation to the

> client. The therapist's intentions are distinctly and only to experience and manifest the attitudinal conditions in such a way that unconditional positive regard and empathic understanding can be experienced by the client. (p. 90-91)

The differences among these positions are substantial. Which of these positions should be considered as defining what it is to be "really" client-centered? Should we struggle for any shared sense of definition, or should we assume that such issues are best left to be decided differently by each individual who chooses to see him or herself as person- or client-centered? To consider these question more carefully, let me present a division of therapy styles which I have developed which contains five "levels of interventiveness."[4]

By "interventiveness," I mean the degree to which a therapist brings in material from outside the client's frame of reference, and the degree to which this is done from a stance of authority or expertise. Levels of interventiveness may be used to characterize particular therapist responses or overall styles of therapy. The levels of interventiveness that I am proposing function, of course, as ideal types. Particular therapist styles or responses may manifest elements of more than one level.

Level 1: The therapist is in contact with the client without bringing anything from outside the client's frame of reference.

Level 1 interventiveness involves undistorted contact with clients, and is a largely hypothetical category. While many of us who are psychotherapists may aspire to empathic contact without filtering or distortion from our own personalities, we seldom realize it in practice. And, certainly, theorists could argue that such contact in a pure form is a philosophical impossibility given the inherent uniqueness and separateness of human consciousness. Perhaps a meditation master in Tibet or a therapist at certain key moments in therapy could communicate at a level of pure psychic energy, with minimal interference from his or her particular personality or frame of reference.

Level 2: The therapist uses personal experiences and theories as a way to more fully understand the client's frame of reference, without trying to influence or alter the client's experience.

At Level 2 interventiveness, the therapist is simply trying to convey his or her understanding of the client's own frame of reference, to feel with the client and to walk in the client's shoes. The ultimate test of a Level 2 response is the client's own sense of being understood in the moment, rather than any more abstract rightness or wrongness of the therapist's statement. Of course, therapists use aspects of their own cultural backgrounds, their particular life experiences, and their general knowledge of psychology to come to understandings of client experiences. Empathic listening as developed by Rogers offers the most fully developed version of Level 2 communication in the clinical literature. Certainly, though, other forms of empathic communication may function at Level 2 interventiveness at certain moments. For example, a therapist might tell a joke that communicates to the client a very deep level of understanding (Bozarth, 1984).

At Level 2 interventiveness there is no concept of "resistance" from the client since the therapist is not trying to get the client to do anything in particular. Level 2 relationships are aspiring to high levels of personal contact combined with low levels of control over client experience. They tend to be grounded in a belief that clients will connect with internally generated developmental processes under certain relationship conditions.

Level 3: The therapist brings material into the therapeutic relationship, doing so in ways that foster the client's choice as to whether and how to use such material.

Level 3 interventiveness still assumes that the client is in charge of the content and direction of therapy, but may find certain resources from the therapist to be helpful in pursuing the client's goals. At Level 3 interventiveness, the therapist may bring ideas, interpretations, suggestions or the like from his or her own frame of reference, but will do this in a way that the client could easily use them in the therapy process or let them go. A number of kinds of therapist responses advocated by some or all client-centered therapists can be considered to fall at Level 3. These include, expressions of therapist reactions grounded in their own congruence, process suggestions, spontaneous therapist comments, and more systematic, though tentatively offered viewpoints.

There is no concept of resistance at Level 3, since the client is still seen as responsible for the overall direction and content of the therapy process. If the client doesn't make use of a particular suggestion or interpretation, this is seen as the client's choice at the moment rather than a problem that the client needs to overcome. Communication styles that are advocated between therapist and client tend to parallel those which are optimal between intimate equals.

Level 4: The therapist brings material to the therapy relationship from his or her frame of reference from a position of authority or expertise.

At Level 4 interventiveness, the therapist is following a model for systematic diagnosis and application of therapist interventions to help the client resolve life issues. In a Level 4 model, the therapist takes on the task of evaluating the nature of the problem, deciding what sorts of interventions are likely to be helpful to the client, and of introducing these interventions to the client in a manner and rate of speed that is tolerable to the client.

Therapies at Level 4 interventiveness tend to be based on personality theories that see clients as likely to resist change in the absence of therapeutic intervention within a carefully structured therapeutic alliance. In Level 4 therapies, the therapist is likely to make a number of decisions on the client's behalf-- evaluating how fast the client can change, the best order of interventions, the best way to introduce interventions to the client and the like. They are likely to make decisions about therapeutic boundaries that they believe are good for the client's change process based on their analysis of the client's personality and level of developmental of maturity.

Level 5: The therapist brings material that is outside the client's frame of reference in such a way that the client is unaware of interventions and/or the therapist's actual purposes in introducing the interventions.

Therapies functioning at Level 5 interventiveness take on many of the authoritative qualities of Level 4 therapies with the added factor that key elements of the therapist's strategies are hidden from the client. Suppose, for example, a therapist thought that a client should be talking about his mother's suicide instead of his inability to finish his college papers. Therapists would be intervening at Level 5 if they established eye-contact whenever the client said anything related to his family and looked away any time that the client began talking about school in the hopes that the client would come to talk more about the suicide. Or similarly, they would be operating at Level 5 interventivenesss if they gave "paradoxical" instructions such as suggesting that the client should try harder to avoid talking about the suicide in the hopes that the client would rebel against the instruction and talk more deeply about the subject.

Level 5 interventions tend to be based on a strong presupposition of resistance, since the therapist typically assumes that no direct approach would generate change as effectively as indirect prescription or influence. This, of course, favors an exceedingly indirect style of therapist communication, since any client awareness of the therapist's intent is likely to undermine the effectiveness of the intervention.

Proponents of the universal nature of Rogers' core conditions would say that empathy, congruence, and unconditional positive regard are relevant to therapies at all five levels of interventiveness. While most practitioners of Level 4 and Level 5 therapies would assert that their interpretations and suggestions have therapeutic value in themselves, many would also agree that the client's belief in the therapist's genuineness, empathy, and caring create a climate in which those interventions are more likely to be effective. And, given Rogers emphasis on the need for therapist genuineness, I believe that he would say that it is better for a therapist to be practicing at Level 4 or 5 than at lower levels of interventiveness if that is what feels most personally right to them.

However, I do not think that saying that Rogers six conditions are relevant to therapies at all levels of interventiveness should be equated with saying that all such therapies are person-centered. I believe that fundamental dividing line occurs between the more client-directed therapies grounded in Levels 1-3 interventiveness and the more authoritative therapies grounded in Levels 4-5. Major differences emerge in two core ways: (1) in the nature of the therapy relationship and (2) in the nature of the client process that tends to emerge within the therapeutic interaction. Client-directed therapy relationships tend to be more equalitarian, focusing on mutual authenticity and shared decision-making. This creates a whole style of relationship with different communication and boundary issues than arise in the more directive, authoritative therapies at Levels 4 and 5.

Therapies at Levels 1-3 tend to focus on the nature of the client's process rather than the therapist's determination of what content he or she thinks would be more optimal in the client's thoughts and behavior. Process theorists (Gendlin, 1968, 1974; Rice 1984; Wexler, 1974) suggest that as clients hold experiences in empathic attention, new experiences tend to come into awareness, change in various ways and reorganize themselves in new configurations. They note that this sort of reorganization of experience occurs particularly strongly when clients attend to aspects of their experience that they have not yet clearly articulated to themselves (Warner, 1996). This sort of client process has characteristics that

are typical in its moment-to-moment unfolding (Warner, 1996; Gendlin, 1968, 1974; Rice 1984; Wexler, 1974) and in the longer-term changes which commonly occur (Rogers 1961, pp.125-159; Barrett-Lennard, 1990). Process-oriented therapies tend to focus on the client's experience in the phenomenological moment, rather than speculating as to where that process might ultimately lead.

There are very real dangers in trying to mix interventions and theories at different levels of intervention, since these therapies are grounded in quite different types of therapeutic relationship. Level 2 responses parallel the empathic responses that would ideally be experienced from parental figures in early childhood, without taking on parental, authoritative decision-making roles on behalf of the client. They may stimulate various wishes, fears, and unresolved issues that exist for the client about any lack of parental empathy and prizing from early in their lives, but they are less likely than other therapies' responses to stimulate issues related to resentment and anger toward authority. For therapists committed to Level 2 interventiveness, responses from outside the client's frame of reference are often seen as superfluous or even damaging to the client's naturally emerging process.

In taking on roles of authority and expertise, Level 4 therapists mimic more authoritative and decision-making roles of parents, and are likely to intensify such issues between client and therapist . Level 4 therapists are likely to see reactions to therapist authority as "resistance," and to work with clients to understand and get past such reactions by seeing the therapist as different from earlier damaging and inappropriate authority relationships. Level 4 therapists often feel the need to keep relatively firm therapy boundaries and to limit the level of self-revelation in their personal communications to avoid opening avenues by which client resistance might come to dominate the therapeutic process.

Therapist responses that have particular effects in therapies characterized by one level of interventiveness may have completely different effects when applied within relationships characterized by another level of interventiveness. For example, Margaret Little (Anderson, 1985; Little, 1990) noted that while she was in a traditionally-oriented psychoanalytic relationship in which her therapist was very predictable and unrevealing (Level 4), minute changes in her therapist's mannerisms were extremely stimulating and unsettling. On the other hand, when she was in therapy with Donald Winnicott, whose style of psychoanalysis was more flexible and with many client-directed (Level 2-3) elements, she was unfazed when he sometimes fell asleep in sessions. (Winnicott was elderly, and quite ill at the time.)

Level 1-3 therapies tend to try to create a climate of safety that permits the client to identify and follow their own impulses to make sense of their experience. Therapies at Levels 4 and 5 tend to offer interventions that create a moderate level of client anxiety and threat, and work to create an alliance that can help the client push past any resistance that is created. Therapists trying to mix therapies between Levels 2 and 4 can easily get the worst of both worlds. They do not create enough safety to foster the self-directed process characteristic of client-centered therapy; on the other hand they don't persist enough to get past the client resistance which arises in response to the more directive, authoritative qualities of Level 4 interventions.

While I believe in the importance of therapists practicing at a level of interventiveness that is personally congruent for them, I don't think that therapists practicing at Levels 1-3 interventiveness have enough in common with therapists practicing at Levels 4-5 that they can learn a great deal from each other. Particular therapist behaviors are likely to have entirely different meanings and impacts in the context of relationships at different levels of interventiveness. Likewise qualities attributed to particular client groups may well be a creation of a particular sort of client-therapist relationship rather than qualities of the clients per se. At the very least, therapists practicing at different levels of interventiveness have to discriminate those aspects of theory and practice that can translate effectively across levels of interventiveness and those which would be ineffective or destructive if carried into a different relationship style.

Given these clusterings of therapeutic issues and strategies, I think that it is both theoretically coherent and pragmatically useful to reserve the term "person-centered" for those therapies which (1) are grounded in Rogers core conditions and (2) emphasize high levels of client self direction (which for me would be manifest by practice focused at Levels 1-3 interventiveness).

More specifically, I propose that person-centered therapists tend to share the following core beliefs:

1. That human beings possess an actualizing tendency which is characterized by both a capacity and an inclination toward self-directed processing of experience;

2. That the actualizing tendency tends to be fostered in relationships characterized by certain core attitudinal conditions--empathy, congruence, and unconditional positive regard;

3. Material brought in from outside a person's frame of reference runs some risk of creating conditions of worth that constrict an individual's ability to process material in a self-directed way.

Person-centered therapy, then, would be characterized by a process in which:

1. The client retains primary responsibility for the content and direction of the therapy, within the legal and ethical constraints of the client and therapist's situation;

2. The therapist aims to maintain the core attitudinal conditions of empathy, congruence and unconditional positive regard to the best of his or her ability;

3. Any material brought into the interaction from outside the client's frame of reference is brought in with care to impinge as little as possible with the client's self-directed process.

In practice, therapists who describe themselves as person-centered virtually all describe practices that I would see as focusing on Levels 2 and 3 interventiveness. Differences among

therapists who define themselves as person-centered tend to revolve around the frequency and rationales used for Level 3 responses (i.e., responses that are outside the client's frame of reference, but which are presented in such a way that clients can easily take them or leave them.).

While person-centered therapists occasionally intervene at Level 4, they tend to see these interventions as a temporary moving a way from optimal therapeutic practice. They are likely to do this in response to some value that they feel is crucially important but not part of the client's own goals for the therapeutic process-- such as preventing immanent suicide or homicide, responding to ethical or legal requirements of the profession, or obeying regulations in the institutions where they work. As such, Level 4 interventions would be seen as involving a temporary stepping away from the kind of process which a client-centered therapist would see as therapeutic.

While the overall emphasis on client self-direction and process give person-centered therapists a great deal in common, differences among therapists I would see as "person-centered" are not at all trivial. In observing these differences, I am not trying to evaluate whether one position is superior to the others, or more "truly" person-centered. I believe that these differences offer legitimate subjects for ongoing debate and differing value-preference. While my own training and practice is closest to the classical position, I have felt deeply understood and helped by therapists working in all of these styles. Let me give an example to illuminate some of the differences of theory and practice that I see within the person-centered movement.

Suppose, for example a client were continuing in a volatile argumentative relationship which included sadomasochistic sexual practices and the therapist found him or herself frustrated by the client's lack of inclination to leave the relationship. Supervisors who self-identify as client-centered might give quite different sorts of advice. A more "classically" oriented client-centered supervisor—perhaps a student of Barbara Brodley -- might advise the therapist to question her own preconceptions about what sort of relationship the client should desire and her reasons for feeling that she should determine this for the client (See, e.g., Brodley, 1990). She might suggest asking the client if he was getting what he wanted for himself out of the therapy relationship, and only initiate changes if the client requests them. Or, she might suggest that the therapist share any persistent reactions she is having to the client's situation as part of her own congruence, without assuming that this will influence the client's goals in any way. However, she would view any systematic analysis of the client's process as a mistake and an imposition of conditions of worth on the client.

A more process-oriented supervisor-- perhaps following the work of Gendlin (1968), (1974), or Rice and Greenberg (1984)-- might advise similar therapist self reflection about her preconceptions about the right outcome for this particular client. But, they would be quite analytic about the question of whether the client's process is engaged in ways that are productive for the client. If the client's process seemed disengaged or repetitive, she might suggest moments in which particular process suggestions might be helpful. She would be likely to advise being very attentive to the client's immediate response to such suggestions, moving away from them if the client objected or seemed to disengage experientially (See, e.g., Gendlin, 1968; 1974). Under these circumstances, analysis of the client's style of

processing is not seen as a mistake. Rather it is central to the therapist's attempts to be helpful to the client.

A third supervisor, perhaps a person defining herself as a "neo-Rogerian," may accept the idea that the therapist sees the client's relationship as unproductive as long as she does not impose that view on the client. She might advocate a relatively equal, collaborative interaction on the subject in which the therapist expresses her views (which may be grounded in some theoretical understanding of the client's personality and development), but also gives great weight to empathic understanding and connection to the client's experiential process as it unfolds. In this case, some theoretically-grounded views as to optimal client outcome would be accepted as long as they were held lightly, and as long as the client's own views and experiential process were given priority.

Notably, therapists from all of these positions try to communicate accurate empathy toward the client's experience. All advocate Level 3 responses under some circumstances. Yet, they differ greatly in the frequency of and rationale for such responses. To outsiders, these differences of rationale are subtle enough to be insignificant. But to practitioners themselves, they are important to the point that that they are often thought of as defining distinctive practices of therapy. Practitioners find considerable value in gathering in smaller organizations and conferences devoted to the particular therapy practices closest to their own. And, I think that therapists sometimes feel more offended by therapies that are small steps away for their own ideology and practice than by those which are clearly and definitively different.

Yet, while I think it is helpful to remain aware of differences among us, I think it is also important to retain a larger identity as "person-centered" psychotherapists. I think that it is a sign of the health and vigor of the person-centered movement that we have a number of quite distinctive "tribes," several of which have generated independent groups of followers, organizations, research and literature. I think it is important to remember that, while we have differences, we also have a great deal in common with each other and a great deal that distinguishes us from more interpretive, confrontive styles of therapy.

I believe that it is crucial that various person-centered therapies maintain an active collaboration for a number of reasons. There is enough similarity in beliefs and practice that therapists from various person-centered subgroups can learn a great deal that is relevant from each other. And, since our differences are grounded in different emphases relative to shared values, debates and challenges are likely to sharpen our own understanding of our own positions and sensitize us to issues that we might otherwise ignore.

And, the various person-centered therapies face a common threat as most industrialized societies are moving in the direction of increasing regulation, bureaucratization and cost-containment of therapy. These trends are tending to undermine therapies that emphasize client choice and self-direction. It is becoming increasingly difficult for practitioners of client-directed, process-oriented therapies to get credentials or to be paid by government or medical insurance. We cannot afford to operate exclusively as individuals or as members of small, disorganized groups that have no consistent organizational presence in the larger world of professional psychology. I think that we should solidify ourselves as a coalition of

therapies under a common person-centered umbrella, celebrating and debating our diversity, while remembering that we are, at core, "one nation" whose commonalities far outweigh our differences.

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[1] In one of Rogers last public presentations, a 1987 symposium in honor of the Chicago Counseling and Psychotherapy Center's 15th anniversary, he noted that he himself did not make a distinction between "client-centered" and "person-centered" psychotherapy. While I recognize that various theorists do distinguish between these terms, for the purposes of this paper I will use them interchangeably, except where I am explicitly exploring potential distinctions between the terms.

[2] A later version of these conditions (Rogers, 1959) differs in a number of details. Notably , Rogers omits the statement that explicit efforts at communicating empathy are essential, stating simply that the "client perceives at least to a minimal degree conditions 4 and 5…"

[3] See, for example, E.T. Gendlin, (1968) and (1974), G. Lietaer (!984) and (1990), L.N. Rice and L.S. Greenberg (1984), and Cain (1989).

[4] In earlier presentations of this categorization of therapies I have called these "levels intrusiveness." I am using a different term here because I have found that the word "intrusiveness" conveys to many people a disparagement of more directive therapies that I do not intend.

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