The Person-Centered Journal, Volume 2, Issue 2, 1995

PERSON-CENTERED THERAPY: A MISUNDERSTOOD PARADIGMATIC DIFFERENCE?

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This paper focuses on several misunderstandings of the person-centered approach which criticize Rogers's conceptualization of the necessary and sufficient conditions for therapeutic personality change (Fay & Lazarus, 1992; Norcross, 1992) and Rogers's theory in general (Cain, 1993; Quinn, 1993). Several of their points are examined and their positions of inquiry challenged from the context of Rogers's theory. The misunderstandings of client-centered theory and practice as interpreted from the framework of other theoretical positions raise an issue of the paradigmatic difference of person-centered therapy from other theories of therapy.

"What if at core there are other urges as motivationally urgent and powerful as the actualizing tendency" (Quinn, 1993, p. 11)?

"The positing of universally applicable factors is the product of myopic schoolism and violates the principle of tailor-making the therapy to the needs of the patient" (Fay & Lazarus, 1992, abstract).

"...if Rogers were correct, there would be no point in bothering to learn any specific techniques – be warm, genuine, congruent and empathic and establish a good therapeutic alliance – period" (Fay & Lazarus, 1992, p. 3)!

"At its worse, Rogers's contentions perpetuated simplistic formulations and singular treatments for all clinical encounters (Norcross, 1991, cited in Norcross, 1992, p. 2).

"...the potential of client-centered counseling is severely limited because of the relative paucity of information that is being incorporated" (Cain, 1993, p. 135).

These quotes are indicative of a process and position taken by authors to criticize the theory and hypothesis formulated by Carl R. Rogers. The process is, in essence, that of dismissing the fundamental assumption of the approach (that of the actualizing tendency and the self authority of the client) as untenable or questionable and proceeding with criticism of the theory from other theoretical frames of reference. The position taken by these authors is embedded to varying degrees on the assumption of the therapist as the expert for the treatment and behavior change of the client. Hence, their theoretical argument is a non-sequitur of the meaning and understanding of Rogers's theory.

A version of this paper was presented with the title of *"Misunderstandings of the person-centered approach"* at the annual conference of the Association for the Development of the Person-Centered Approach, Maryville, Tennessee, May, 1993.

The intent of this article is to identify some of the factors that underlay these misunderstandings and to crystallize the basic properties within the person-centered paradigm.

THE THEORY

A brief recapitulation of Rogers's theory is that there is one natural motivational force in human beings that is constructive and growth directed; that is, the actualizing tendency. This natural growth tendency is thwarted by the conditional positive regard individuals receive, perceive and introject from significant others. An individual then develops conditional positive regard towards him or her self and, concomitantly, the actualizing tendency is thwarted. It is when the individual perceives unconditional positive regard from a significant other that he or she develops unconditional positive self regard and, concomitantly, the process of actualization is promoted (Rogers, 1959). The process of actualization is a functional construct in Client-Centered Therapy (Bozarth & Brodley, 1991) which assumes an individual as well as a general process in that there is a striving for each person to meet one's potentialities. *Each individual is his or her unique process.*

Rogers (1957;1959; 1986) hypothesized the necessary and sufficient conditions for therapeutic personality change as part of the client-centered framework and as central in all types of positive interpersonal relationships. In this formulation, he said that if the client perceived the therapist to be congruent and if the therapist consistently experienced empathic understanding and unconditional positive regard towards the client that therapeutic personality change would ensue. Rogers (1961; 1980; 1986) discussed these conditions and speculated upon variations (Baldwin,1987) throughout his life. However, Rogers's openness to new ideas and change never necessitated that he alter his basic theory and practice. His dedication to change did not alter his disciplined and rigorous delineation of the theory (Rogers, 1959) in which the bedrock of therapeutic change is the client's experiencing of unconditional positive regard. I (Bozarth, 1992) have suggested that Rogers's (1959) major theoretical statement poses the conditions of congruency, empathic understanding, and unconditional positive regard as theoretically highly interrelated but that the importance of therapist congruency or genuineness is primarily that of enabling the therapist to better experience the other two conditions towards the client. Moreover, empathic understanding is viewed as the most pure way for the communication of unconditional positive regard. In essence, Rogers contended that psychological dysfunctions of individuals are due to the thwarting of their natural growth by conditions of worth being introjected from significant others. Subsequently, psychological growth and problem resolution result from the individual being freed of these introjections and the development of conditional self-regard.

CRITIQUE OF CRITICISMS

The theoretical position cited above is important since, as Quinn (1993) states: "This belief leads in practice to a faith on the part of the therapist that the client will do the bulk of the work in therapy; that the client will be in charge of movement and the directions of growth" (p. 11). Quinn, who apparently believes he is "Confronting Carl Rogers" and who identifies himself as a client-centered therapist, provides a classic example of dismissing the fundamental assumption and the subsequent implications for growth. Quinn decides, while recognizing that fundamental assumptions are "ultimately unprovable," that we might ask whether or not there are ". . .other urges as motivationally urgent and powerful as the actualizing tendency" (p. 11)? This may, of course, be a viable dialogue and one which Ford (1994) adeptly clarifies. However, Quinn simply dismisses Rogers's assumption as untenable. With that dismissal of the basic assumption of client-centered theory, he proceeds to conclude from his clinical experience that confrontation is ". . .absolutely necessary to successful outcomes. . ." (p. 11). In short, he communicates his lack of trust in the assumption and then finds anecdotal support in his clinical work which verifies

that one cannot trust the assumption. Quinn then continues by criticizing client-centered theory within the context of "secondary gains," and "social learning theory" which of course are concepts founded upon completely different basic assumptions. By the time Quinn solves the problem of person-centered therapy being too person-centered (which is a problem he creates) and actualization as too positive, he can conclude that ". . .there is often a need (usually later in therapy) for some contradiction, some nudging, some confrontation, that is, saying some hard truths that help a client move toward fuller functionallity" (p. 11). Ergo, the client is no longer the the one who knows best about his or her life and the therapy can then be improved by the therapist adapting an additional and different set of assumptions from other theoretical frames of reference.

Likewise, Cain (1993) who was the prime initiator of both the Association for the Development of the Person-Centered Approach and the journal, *The Person-Centered Review*, misses the whole basis of the theory when he contends that ". . .the client-centered community in general have remained rather insulated from and unaffected by the enormous advances in knowledge in the fields of...and other approaches to counseling and psychotherapy" (p. 135). New knowledge has to be consistent with or sufficiently challenging to basic theoretical premises to be integrated or, indeed, must be integrated in ways that fit the basic assumptions of the theory. Advances in knowledge that are based upon the very assumptions of therapist expertise that are antithetical to the client-centered position that "trusts the client as his/her own best authority. . ." (Bozarth, 1990, p. 63) is, at best, an irrelevant point.

Others exemplify the inaccuracy of viewing Rogers's theory from the perspective of different frameworks when they conclude that Rogers is suggesting a ". . .unitary case formulation and universal treatment plan" (Norcross, 1992, p. 8) and that Rogers ". . .violates the principle of tailor-making the therapy to the needs of the patient" (Fay & Lazarus, 1992, p. abstract). The perceptual stance of these authors that the clinician is an artful director of prescriptive matching for tailor making treatment to the individual is so radically different from Rogers's assumption of the client knowing what is best in his or her life that they have an ironic misunderstanding of person-centered therapy. They somehow do not understand that the practice of person-centered therapy is focused on individual differences and not predicated on ". . .doing something to the client that is predetermined by an authoritative therapist who takes responsibility for the treatment and behavior of the client" (Bozarth, 1991, p. 467). The experiencing of certain attitudes towards a person is not the same as prescribing ". . .relationship stances and technical interventions for each situation. . ." (Norcross, 1992, p. 8). Fay and Lazarus are replete in their amazement of a different way of relating to people when they sarcastically state: ". . .if Rogers were correct, there would be no point in bothering to learn any specific techniques–be warm, genuine, congruent and empathic and establish a good therapeutic alliance–period" (p. 3)! Ironically, this is exactly correct. What one does as a person-centered therapist is what emerges in the relationship with the client. It is partly allowing the person the freedom to find his or her own ways of dealing with their problems by being in and accepting the client's perception of the world; hence, creating an atmosphere of unconditional positive regard. In the context of client-centered theory, it is creating an atmosphere of unconditional positive regard that enables the person to develop unconditional positive self regard and, subsequently, to resolve his or her specific problems. The theory is not one which applies certain conditions the way one applies dosages of drugs to a person in an effort to finalize a treatment plan. The therapy is a human endeavor that does trust the growth of each individual, and wherein the therapist resonates in person to person ways. Quinn's statement is exactly correct that the belief in the actualizing tendency ". . . leads in practice to a faith on the part of the therapist that the client will do the bulk of the work in therapy; that the client will be in charge of movement and the directions of growth" (p. 11). Somehow this seems difficult for therapists to assimilate when their perceptual stance is that of the expertise of the therapist. This

seems increasingly true whether they identify themselves as client-centered therapists or behavioral therapists or integrationists.

CENTRAL ISSUES

Why is there such a lack of understanding or acceptance of person-centered therapy? Why do eminent scholars with high integrity, including those who identify themselves as client-centered, fail to understand and/or accept the foundation block of client-centered theory? It might be helpful to attempt to identify some of the factors that underlay these misunderstandings and to crystallize the basic properties within the person-centered paradigm.

The Perceptual Stance

The first and foremost factor appears to me to be that their perceptual stance does not permit them to understand a theoretical base that so radically trusts the client in therapy. Thus, they in various ways summarily dismiss the position and misconstrue the meaning. To repeat, Quinn as an example seems to not accept his accurate assessment of the approach: ". . .that the client will do the bulk of the work in therapy; that the client will be in charge of movement and the directions of growth." Whereas the extent of this trust *is* the critical difference between person-centered therapy and other therapies. As Rogers and Sanford (1984) in accord with Albert Szent-Gyorgyi state: ". . .there is definitely a drive in living matter to perfect itself" (p. 1382). Person-centered therapy lies in the basic trust of this drive towards perfection. *It is the client who knows best where to go and how to get there.* Since this is an unacceptable position to many practitioners and scholars, they integrate it into their own perceptual scheme. Representative of this action are those scholars cited above who must reintegrate the therapist attitudes of the necessary and sufficient conditions to a "treatment modality" that is a "unitary treatment" phenomenon. Rogers's conceptualization of therapist attitudes and experience toward another human being are thus transmuted to a technique incorporated under such terminology as technical eclecticism. Norcross (p.8) is, for example, clear on his paradigmatic difference from the person-centered stance when he adheres to the specificity question: "What treatment by whom is most effective for this individual with that specific problem under what set of circumstances?" (Paul, 1967, p. 111). In addition, their perceptual stance leads them to conclude that psychological research has refuted Rogers's conceptualization of the necessary and sufficient conditions and to find that specific treatment "tailor made" to clients with particular dysfunctions is a proven fact (Lazarus & Lazarus, 1992; Norcross, 1992). There are, of course, other interpretations of the research literature (Bozarth, 1991; Bozarth & Stubbs,1991; Stubbs & Bozarth, 1994; Patterson,1984). More recently, several authors (Lazarus, 1993; Norcross, 1993) have acknowledged that research findings suggest that the greatest contributors to the effectiveness of psychotherapy are client and relationship variables. They, however, assume that the therapist can create a designated relationship for a particular client; hence, holding to the expertise of the therapist.

Cain's somewhat similar perceptual stance is that the client's capacity of finding his or her own direction can be helped by the non-interventive expertise of the therapist using various forms of encouragement and/or expertise. Thus, Cain (1993) concludes that Rogers's theory is of ". . .little help in understanding the wide varieties of disturbing and pathological behaviors (e.g., depression, obsessive-compulsive behavior, disturbed body image) that render people dysfunctional to varying degrees" (p.136). This simply ignores Rogers's theoretical position that such labels are meaningless and that as the person develops increasing positive self regard, the "dysfunctional" problems are dealt with by the person.

In summary, the perceptual stances result in misunderstanding and/or failure to assimilate "...the most revolutionary and most fundamental and potent therapeutic element in Rogers'

approach" (Brodley, 1993, p. 142). This element is, in Brodley's words, ". . .the functional role of the actualizing concept, which shapes the counselor's experience and expression of the specific therapeutic attitudes. . ." (p. 142).

"Doing" and "Being"

The second albeit related problem with articles which purport to criticize Rogers's conceptualizations seems to me to be the confounding of the therapist "doing" and "being" in person-centered therapy (Bozarth,1992). From the perspective of viewing the therapist as an expert who does something to/for the client, it might seem that the person-centered therapist does have the same treatment for all problems.

When viewed from the perspective of the therapist experiencing certain attitudes toward a person, whatever the therapist does that is ethical and consistent with the principle of dedication to the trust of the growth process of the client is appropriate. What one does as a therapist only contaminates the client-centered position ". . .when the therapist assumes that he/she knows what is best for the client, what is wrong with the client or what direction the client should go" (Bozarth, 1992, p. 17). In short, the person-centered therapist is not treating the client. Rather, the therapist is providing an atmosphere by experiencing certain attitudes toward the person which then frees the person to resolve his or her own problems and dysfunctions.

SUMMARY

In my view, the authors cited above misunderstand and distort client-centered theory in that they hold the view that the therapist best knows the process and even knows the ultimate goal of the client. Rogers's view that the client knows what is best is compromised by the therapists' "expertise." Adherence to client-centered theory then depends upon the extent to which the therapist is willing to give up and/or the client is able to overcome the "interfering interventions" which are posed to the client.

The person-centered therapist operates within a different paradigm (Bozarth, 1985) than do most other therapists in that the person of the client is always considered his/her own best expert about his/her life (Bozarth & Brodley, 1991). Others may not like this position nor believe the position and may twist or criticize the theoretical assumptions. However, dismissal of the theoretical assumptions leading to evaluations of the theory from other theoretical assumptions is simply a non-sequitur of the basic meaning of Rogers's theory. Rogers's extensive trust in the actualizing process of human beings suggests to me that Client-Centered/Person-Centered therapy is functionally a different paradigm from other therapies. As such, the principles may permeate other theories but the fundamental stance is radically different in that the client is the one who knows best about his or her life.

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