ON BEING CLIENT-CENTERED

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Currently, many suggestions have been made for expanding, extending, or modifying the client-centered approach. The consistency of these suggestions with the basic philosophy and principles of client-centered therapy is questioned.

The purpose of this paper is to consider the trend toward expanding or extending client-centered therapy, introducing new or "innovative" methods and techniques, going beyond the necessary and sufficient conditions postulated by Rogers (1957). Attempts have also been made to integrate client-centered therapy with other approaches, such as Jungian therapy (Purton, 1989). The question is raised about the consistency of these additions, extensions, and integrations with the basic philosophy and assumptions of client-centered therapy.

THE PROBLEM

As I have met, listened to, and talked with persons who profess to be client-centered, and as I have read the writings of others who profess to be client-centered, I confess to some puzzlement and concern. It seems to me that they have departed from the basic philosophy and principles of client-centered therapy.

Wood says that "some of Rogers' closest colleagues use hypnosis, guided fantasies, paradoxical statements, dream analysis, exercises, give homework assignments and generally follow the latest fads" (1986, p. 351). Natiello says that "many therapists who call themselves person-centered now direct their clients by using procedures such as hypnosis, relaxation, psychodrama, and so on" (1987b, p. 246). She herself proposes adding therapist power as a fourth condition to Rogers's three (1987a).

This leads me to wonder if it is clear just what the client-centered position is--what are its philosophy, beliefs, and assumptions. Rogers and others have written extensively about this, of course. And recently Combs (1986a) and Bozarth and Brodley (1986) have explicated the position. Yet its implications do not seem to have been recognized or understood. The three therapist conditions postulated by Rogers (1957) are given almost universal lip service as necessary, though Wood says that "Most people [and he seems to be including those who call themselves client-centered] repeat vacuously the cliche: 'I believe that Rogers' conditions are necessary, but not sufficient' " (1986, p. 351). It would seem that with the considerable evidence

that the conditions are sufficient (e.g., Patterson, 1985, pp. 217-220, chap. 13), to be client-centered would require acceptance of their sufficiency until evidence to the contrary existed.

That it is not clear what is client-centered, and also what is not client-centered, is shown by Jennings's person-centered approach to dream analysis. Jennings illustrates this in his analysis of a client's dream. Stating that his objective is to have the client make her own interpretation of the dream, he directs the analysis following his system of dream analysis. The means is inconsistent with the end; he assumes the responsibility for the analysis. Purton (1989) also refers to "exploring dreams in a person-centered way" (p. 415) but does not explain how this is done. He also suggests a fourth necessary condition, "an attitude that could be called 'openness to the unconscious' " (p. 412).

There are numerous other examples of writers suggesting that we should break from "traditional" client-centered therapy. According to Bozarth and Brodley, Gendlin (1974) and Rice (1974) "suggested that the therapist at times knows the best direction for the client" (1986, p. 267). Combs suggests that since "counseling is essentially a learning process," counselors "ought to acknowledge the teaching role and use it, purposefully, for positive ends," though "the concept of teaching, for many therapists, is practically an epithet, synonymous with autocrat or dictator. I think these attitudes are unnecessarily inhibiting" (1988, p. 268). He does not discuss just how the client-centered counselor teaches, or how this is consistent with client-centered principles.

Warner (1989) attempts to integrate strategic family systems theory into client-centered family therapy. However, it is not clear just how the therapist functions, but the use of terms such as "urging," "interpret," "very few [but presumably some] demands or suggestions," "address incongruence," "raising possibilities" does not appear to be consistent with client-centered therapy.

And Snyder (1989), attempting to integrate Rogers and Bateson in couple therapy, does not appear to function in consistency with the principles of client-centered therapy. She refers to her relationship enhancement model as therapy. She also refers to it as "a skill training model" (p. 376). It is actually teaching, not therapy.

At least one other client-centered therapist shares my concern (J. M. Shlien, personal communication, 1986). Referring to "new directions," and to "innovations" that make "novelty a virtue in itself," Shlien notes that "the question is not 'what's new,' but what is good" (1986, p. 347). He goes on to say that "one reads that client-centered therapists include in their practice hypnosis, scream therapy, behavior modification, Gestalt psychodrama, relaxation, etc. How some of these can be considered client-centered is beyond me.... The person-centered approach invites extensions that sometimes outreach the theory of client-centered therapy" (pp. 347-348).

And Raskin (1987), in his review of Levant and Shlien (1984), refers to chapters by Gendlin, Rice, and Guerney, and by others, which are aimed at “broadening both the theory and practice of client-centered therapy . . . practices designed to make more efficient the client's problem solving and experiencing endeavors.... On the one hand, such divergent approaches . . . are consonant with Rogers' hope that his students would not turn out to be little Rogerians, but would develop their own ways of working.... On the other hand, each of these neo-Rogerian

methods takes something away from the thoroughgoing belief in the self-directive capacities of clients so central to client-centered philosophy. (p. 460)

Are there no limits to what can be called client-centered? Is anything that is done by a therapist claiming to be client-centered actually client-centered? Did Rogers, in his modesty and openness to new ideas, issue a license for client-centered therapists to do whatever they feel like doing and still claim to be client-centered?

Perhaps we need a more specific analysis of what client-centered therapy is and what it is not. There are some things that are inconsistent with the philosophy and beliefs or assumptions of client-centered therapy. There are limits to what a therapist can do and yet remain client-centered. As Shlien says, "It is essential to find a set of criteria to define the meaning of client-centered" (1986, p. 348).

BASIC PHILOSOPHY AND ASSUMPTIONS OF CLIENT-CENTERED THERAPY

1. Every organism is motivated by one basic drive, the drive to actualize its potentials, at the biological and psychological levels (Patterson, 1964). Combs and Snygg explain that "from birth to death the maintenance of the phenomenal self is the most pressing, the most crucial, if not the only task of existence.... Man seeks both to maintain and enhance his perceived self" (1959, p. 45).

Rogers has stated this assumption in various ways, speaking of a growth tendency: "The organism has one basic tendency and striving--to actualize, maintain, and enhance the experiencing organism" (1951, p. 247). Later, he refers to "man's tendency to actualize himself, to become his potentialities. By this I mean the directional trend which is evident in all organic and human life--the urge to expand, extend, develop, mature, the tendency to express and activate all the capacities of the organism, or the self . . . it exists in every individual, and awaits only the proper conditions to be released and expressed." (1961, p. 351)

Later, Rogers talks of "an underlying flow of movement toward constructive fulfillment of its [the organism's] inherent possibilities" (1984, p. 117). "It is clear that the actualizing tendency is selective and directional--a constructive tendency, if you will" (p. 12); the actualizing tendency and "a formative tendency in the universe as a whole . . . are the foundation blocks of the person-centered approach" (p. 114); and "the person-centered approach rests on a basic trust in human beings, and in all organisms" (p. 117).

2. Certain environmental conditions must be present for the actualizing tendency to operate. The biological organism needs air water, food, and often clothing and shelter to survive. But biological survival requires another condition--nurturing, caring, and loving by another person (Spitz, 1945; Lynch, 1977). In addition, certain information, knowledge, and skills are necessary. At the psychosocial level, a caring, loving environment is necessary for the social-emotional development of the individual. These are the conditions provided in client-centered therapy, which have been identified as empathic understanding, unconditional positive regard (respect, caring), and therapeutic genuineness.

3. Persons come to psychotherapy not because they lack biological necessities or information or skills (though some may lack these things). They come because of social-psychological needs--emotional and interpersonal deficiencies. Therapists do not provide the biological necessities; some, however, perhaps mistakenly, feel that they should provide the information, knowledge, and skill deficiencies--that they should be teachers.

The three conditions postulated by Rogers are necessary and sufficient where there are no physical or information or skill deficiencies.

4. The goal of psychotherapy is to promote the self-actualization of the client. The conditions provided by the therapist in the therapeutic relationship are the specific conditions for the lack or insufficiency of these conditions in the past and/or present interpersonal environment of the client (Patterson, 1985).

5. The presence of the actualizing tendency in the client makes it possible for the client to control and direct the therapy process. Each client has multiple potentials and chooses those that will be actualized, and the ways or manner of actualization.

In the process the client takes responsibility for him-or herself; engages in the self-disclosure and self-exploration necessary for therapeutic progress; engages in problem solving, and makes decisions and choices. The actualizing tendency as manifested in these characteristics means that the therapist need not engage in active interventions; provide or suggest alternatives; suggest solutions to problems; question or probe; offer interpretations or insights; or offer praise, encouragement, or reassurance. The therapist is not a director or even a guide; the specific path to self-actualization is not known to the therapist. The therapist trusts the actualizing tendency in the client, has faith that the tendency will manifest itself under the conditions offered by the therapist, and has the patience to allow the client the responsibility to direct the process and to progress at his or her own rate. The therapist is always responding to, or is responsive to, the client in the process.

For any particular client, it is assumed that the client has the necessary drive toward growth and self-actualization. The actualizing tendency may be minimal or even lacking because of organic damage or past and/or present deprivation or mistreatment. Rogers, however, believed that though "the actualizing tendency can, of course, be thwarted or warped . . . it cannot be destroyed without destroying the organism" (1984, p. 118).

6. While the three therapist conditions of empathic understanding, unconditional positive regard or respect, and therapeutic genuineness may be sufficient, the question remains whether they are efficient. Are there other conditions, not necessary, that can improve the efficiency of the process, or facilitate or expedite it? This, it seems to me, is what many practitioners, such as those cited earlier, are looking for. It is possible, for example, that relaxation processes and hypnosis could be used in a manner consistent with client-centered principles (Moore & Patterson, "Client-Centered Therapy and Hypnosis," paper in preparation). The essential requirement of any these processes is that they be consistent with the theory and philosophy of client-centered therapy--that is, that they do not take away the client's autonomy and

responsibility, the client's opportunity to "do it for him/herself." Anything that deprives the client of this experience fosters dependence and detracts from the self-actualizing process in the client.

7. The three basic therapist conditions are present in all the major therapies. But client-centered therapy is unique in its position that these conditions are sufficient, and in its consistent adherence to these conditions.

a. Client-centered therapy remains in the internal frame of reference of the client through the entire process. It neither limits the practice of empathic understanding to the development of so-called rapport, nor uses the understanding as a power base to intervene, direct, and influence the client through interpretation or other means.

b. The client-centered therapist respects and trusts the client to the extent that the client is given control of the nature and rate of development of the therapeutic process. The therapist's trust in the client is not limited or restricted: It is complete.

c. The therapist remains constantly in the responsive mode, never leaving it to initiate, direct, or control the process through interventions.

No other approach to psychotherapy operates in this manner. Thus, it is not possible to integrate client-centered therapy with any other approach, nor to take or use methods or techniques from other approaches, which are usually direct interventions inconsistent with the client-centered philosophy and theory.

Apparently many seem to feel that the position taken here is narrow, rigid, and dogmatic. Yet it is logically necessary if one accepts the philosophy and assumptions of client-centered therapy. Some appear to feel that if one has the attitudes (represented in the conditions), one can do anything one feels like in therapy and still be client-centered. Rogers (1975) appears to have fostered this attitude: "I've come to realize that techniques are definitely secondary to attitudes, that if a therapist has the attitudes we've come to regard as essential probably he or she can use a variety of techniques." Cain writes that "certainly being person-centered must mean more than possessing these qualities, as nice as these qualities are" (1986, p. 251). He notes also that "although being client-centered has some boundaries regarding our beliefs and the manner in which we implement them, it seems that the qualities or attitudes that derive from our philosophy also free us to define ourselves in our own unique manner of being client-centered.... Somehow I like the idea that person-centeredness offers more freedom than limits." (p. 255)

The client-centered conditions can be implemented in different ways by different therapists with different clients. However, these ways must always be consistent with the basic philosophy and the nature of the conditions themselves. There is some freedom. But there are limits. The freedom of the therapist stops when it infringes on the freedom of the client to be responsible for and direct his or her own life.

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