

INVOLUNTARY CLIENTS: A PERSON-CENTERED VIEW

C. H. PATTERSON

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The purpose of this paper is to consider the problem posed by so-called involuntary clients in client-centered therapy.

Actually, there is no such thing as an involuntary client. Psychotherapy is a relationship entered into for the purpose of client change. It takes two to form a relationship. A person becomes a client when he or she voluntarily enters a relationship with a therapist. The term involuntary client refers to persons who, in the view of others (family members, teachers, associates, the courts), have a problem and are referred to, or are required to present themselves to, a therapist. However, they do not see themselves as having problems, or as in need of psychotherapy. Rogers (1957) states as one of the conditions of psychotherapy that the client is incongruent, vulnerable, and anxious. That is, he or she "must be someone who is feeling some concerns . . . some degree of conflict, some degree of inner difference, some expression of concern" (Rogers, 1987, pp. 39, 40).

Therapy is not something that can be imposed on someone, or given or administered, like a shot of penicillin. A person does not become a client until he or she decides to become one. So-called involuntary clients are persons who reject or decline psychotherapy and refuse to become clients.

Such persons, because they present themselves, or are brought, to a therapist, constitute a problem for the therapist. They are often considered to be unmotivated. But as there is no such thing as an involuntary client, there is no such thing as an unmotivated client (Patterson, 1964). They are unmotivated for psychotherapy, but they are motivated to avoid participating in psychotherapy. They are not motivated as we would like them to be motivated.

Rogers (Rogers & Stevens, 1967), writing of his experience with unmotivated clients, notes that "the absence of conscious motivation constitutes a really profound problem in psychotherapy.... There is a great difference between working with the consciously motivated client, whether neurotic or psychotic, and working with the person who has no such conscious motivation, whether that person is normal, neurotic, or psychotic." (p.183)

Here the term unmotivated client refers to the client who has no conscious desire for help, that is, the involuntary client. He continues: "For working with the person who has no conscious desire for help we need, I believe, a new term.... It is my present conviction that working with a lack of

conscious motivation in the individual is more difficult than working with the problem of psychosis" (pp. 183, 184). Referring also to working with unmotivated normal people of low socioeconomic status, Rogers says: "I believe the absence of conscious desire for help presents a greater challenge to the therapist than the presence of psychosis" (p.184). Then, significantly, he continues:

"In any event, I have come to believe that we will make more progress in this area if we recognize that dealing with the person who does not wish help is a clearly different undertaking from psychotherapy, and if we build up the concepts, theories, and practices appropriate to it we should not be misled by the fact that *a relationship with such an individual may become psychotherapy when he chooses to seek help*" (p.184, italics added)

Rogers does not go on to suggest any such concepts, theories, and practices. Nor has anyone else done so, to my knowledge. Thorne (1968) suggested that the therapist attempt to create or induce a conflict in the client by bringing into consciousness inconsistent and conflicting attitudes. When the client becomes aware of the inconsistency, he or she will be motivated to resolve it. But he noted that "the use of induced conflict . . . must be handled with great caution . . . efficacy of the technique depends upon the clinical sagacity of the case handler, who must be able to guide the therapeutic process in positive directions" (p. 453). I am very skeptical about the success of this method. At the very least it will induce or provoke resistance. But then any method of intervention is likely to provoke resistance in persons who are not voluntarily present with a therapist. No doubt therapists have tried many kinds of interventions--questioning; probing; offering suggestions, advice and guidance; moralizing; admonishing; even threatening--undoubtedly with little effect. In fact, such methods may reduce the possibility that the person will enter a therapy relationship and become a client.

But what about the growth tendency, the drive toward self-actualization, assumed to be present in every person? It is "the tendency upon which all psychotherapy depends" (Rogers, 1961, p. 35). But it is only a tendency, even though universal and often strong. "This tendency may become deeply buried under layer after layer of encrusted psychological defenses; it may be hidden behind elaborate facades which deny its existence" (p. 35). And it may have been suppressed by destructive or inhumane treatment by others. But it is Rogers' "belief that it exists in every individual, and awaits only the proper conditions to be released and expressed" (p. 35).

What are these conditions? They are the well-known conditions of client-centered therapy--empathic understanding, respect or warmth, and therapeutic genuineness. But the problem inheres in the fact that these conditions must not only be provided by the therapist; they also must be perceived by the person to whom they are offered. As Rogers (1957, p. 96) puts it, "The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved." So-called involuntary clients will not, or cannot, recognize and accept the understanding, interest, and concern of the therapist. They will not or cannot trust the therapist.

Yet if, as Rogers has stated it, these therapist and client conditions are the necessary and sufficient conditions for therapeutic personality change (Rogers, 1957), there is no other way to

achieve such change. Behavior can be changed in other ways--by threat, coercion, brain surgery, drugs. But lasting change through self-discovered learning does not follow such changes.

The only solution to the problem appears to be through persistent offering of the conditions until, in some cases at least, they are perceived and accepted by the person to whom they are offered, who then becomes a client. Gendlin (1962) has described his work with hospitalized schizophrenic patients, some of whom were reached. Rogers, Gendlin, Kiesler, and Truax (1967) also report some success with hospitalized schizophrenic patients. Therapists who work with persons in the criminal justice system achieve some success. Three of my former students at the University of Illinois have been working for almost 15 years with adolescents on probation, with some success. The success rate with both these groups (psychotics and delinquents) is low, and anyone working with such persons should not require a high success rate for personal or professional satisfaction. But such persons should not be rejected. Working with them could be a long, slow process. But the persistent offering of a relationship--communicating interest, concern, caring, respect, and understanding--can succeed in some cases, making the effort worthwhile. Resistance, antagonism, rejection, lack of interest are to be expected; they are met with acceptance and patience--without questioning, probing, confrontation, or pressure.

Some therapists may not believe that such an approach is effective. They do not have the patience or do not want to invest the time and effort necessary to finally establish a relationship. So they abandon the necessary and sufficient conditions for psychotherapeutic change and attempt to effect change through confrontation, argument, persuasion, coercion, and other methods. They are not likely to be successful in achieving lasting change.

CONCLUSION

The problem of reluctant or so-called involuntary clients is a difficult one. It is becoming more common as therapists are expected to work with people who do not voluntarily come for help, such as substance abusers. Directive and educational approaches can have a place in group work with such persons, but there is no substitute for the necessary and sufficient conditions for therapeutic personality change.

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