SOME MISCONCEPTIONS OF AND QUESTIONS ABOUT CLIENT-CENTERED THERAPY

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One of the oldest misconceptions about client-centered or relationship therapy is that the therapist is a purely passive participant in the process. Perhaps the use of the term *nondirective* with reference to the therapist has encouraged this view. The still continuing use of the term keeps this misconception alive.

It was about 1948 that an apocryphal story began circulating that parodied the idea of passivity. Carl Rogers, it was said, was counseling a client in an office high up in an office building. The client: "I feel terrible." Rogers: "You feel terrible." The client: "I really feel terrible." Rogers: "You really feel terrible." The client: "For two cents I'd jump out of that window." Rogers: "For two cents you'd jump out of that window." Client, getting up and going to the window: "Here I go." He jumps out of the window. Rogers, getting up and going to the window: "There you go." Another line was apparently added later. The client hits the ground with a plop sound. Rogers: "Plop."

It should be apparent from earlier chapters that the counselor or therapist is far from being a passive participant. The therapist is a highly sensitive, active, empathic listener, constantly struggling to understand the client, from the client's frame of reference, and to communicate this understanding in a way that facilitates the client's further self-exploration. The therapist is active in responding to the client, rather than in initiating or leading.

This story also illustrates two other misconceptions. First, that client-centered or relationship therapy is simple, even simplistic. It has been referred to as the grunt and groan method, or the uh-uh system. Again, it should be clear from earlier chapters, and from the writings of Carl Rogers and others, that it is far from a simple parroting back of the words of the client. The other misconception that appears in the story is that the method is purely a matter of technique--indeed, of one technique, that of reflecting the statements of the client, or paraphrasing them. But it should be clear at this point that relationship therapy is far from a simple technique or a bag of techniques. It involves the whole therapist as a person--his or her attitudes, values, and philosophy. No array of techniques, no matter how skillfully practiced, can lead to a real therapeutic relationship.

Another persisting misconception is that relationship therapy is useful, but only with a limited group of clients and problems. That is, it is appropriate only with clients of above

average intelligence, such as college students, with simple adjustment problems, but not with seriously disturbed clients or those labeled or diagnosed as psychotic. Yet it has been successful with such clients. Gendlin (1), among others, has reported on his work with schizophrenic patients. The extensive research by Rogers and his associates at the University of Wisconsin (2) should have dispelled the myth that client-centered therapy was not effective with psychotics. Critics have apparently misunderstood or misrepresented this study and have dismissed it, or have complained that not every patient improved. No method, of course, claims or should be expected to achieve 100 percent success.

Another misconception about relationship or client-centered therapy is that it is purely or essentially affective in nature, dealing only with feelings, and ignoring or rejecting cognitive or intellective aspects of clients and their problems. While it is true that client-centered therapy in its beginnings focused on affect, in contrast to the focus of other counseling approaches on cognitive factors, and while the emphasis is still upon affective elements, it is not possible to exclude cognitive factors, either in the client or the therapist, from the therapy relationship. The therapist relates to the client as a whole and total person, including thoughts, intentions, and actions as well as feelings and emotions. Contributors to the volume edited by Wexler and Rice (3) consider the cognitive, information processing, and language factors in the therapy process.

SHORT-TERM AND LONG-TERM PSYCHOTHERAPY

What might also be considered a misconception is that relationship therapy is long-term therapy. A method that leaves the initiative and responsibility with the client must be slow, and to allow the client to decide when to terminate therapy must prolong it. But this is not necessarily true.

Currently there is a strong emphasis on short-term or brief psychotherapy. It is interesting that it is in America, with its focus upon efficiency, where this emphasis is greatest. The psychoanalysts have been criticized because their methods result in therapy that lasts for several years. Some have developed methods to shorten the orthodox approach, calling these briefer approaches psychoanalytic psychotherapy to distinguish them from orthodox psychoanalysis (4).

A common characteristic of the brief psychotherapies is their active, directing, and controlling nature. These therapies go beyond the responsive conditions, employing a wide variety of directive techniques. Where time is limited, either by pressures upon therapist time, as in mental health centers, or by client factors such as limited financial resources and mobility, it is felt to be necessary or desirable to resort to methods to speed up the process. It is assumed that the client-centered or relationship approach is too lengthy.

Two comments are in order here. First it should be noted that the objectives of brief therapy are different from those of extended therapy. The accepted or recognized objective is to provide immediate, if temporary, relief for the client's distress, and to resolve current specific problems. But this has some unintended outcomes. The use of directive methods means the abandonment of the objective of client responsibility for choices, for solving problems, even for his or her own life. Dependency can be fostered, so that whenever the client encounters another problem or difficult situation, he or she returns for help. Or, if the client feels that he or she was not helped, or was pushed out of therapy too soon, a new source of help is sought. The result can be a revolving door phenomenon. It is possible that this short-term, sometimes limited time policy of community mental health centers is creating a large group of dependent persons who will continue to need help for long periods of time. A student of mine in a practicum at a community mental health center was assigned such a returning client. The client wanted to know whether she would be limited to six interviews this time before she would enter a relationship.

The second comment is simply that relationship or client-centered therapy is not usually long-term therapy. Giving the decision of when to terminate to the client does not lead to interminable therapy. Yet it must be recognized that clients need therapy of varying duration. Some need only a few interviews, but some need lifelong therapy if they are to remain out of an institution. It is much more cost-effective to provide an hour a week of therapy than to commit a person to an institution, perhaps for the rest of his or her life.

The basic principle of the approach represented in this book is that the best way to help a client, whether only for an hour or for a hundred hours, is to provide the highest level of a therapeutic relationship of which the therapist is capable.

THE RELATIONSHIP: SPECIFIC OR NONSPECIFIC?

There is currently general agreement among theorists and therapists that the relationship factors of empathic understanding, respect or warmth, and therapeutic genuineness are present in all systems or methods of psychotherapy. Therapy, by almost any definition, involves a personal contact between the therapist and the client. This universal presence of a psychological relationship constitutes an obstacle to research attempting to study the influence or effect of other factors, such as specific techniques, apart from the relationship; the relationship cannot be eliminated and is difficult to control. No study to date has been successful in this respect. One study purporting to do so was not in fact free from relationship factors (5). This study involved a laboratory study of fear modification using an automated desensitization procedure. Instructions to the subjects were taped; the subjects listened to the tapes instead of being involved with the therapist. But the tapes were of a human voice, and the experimental situation involved relationship elements--the subjects were introduced to the experiment by persons. The possibility that were introduce the subjects anthropomorphized the machine was present. In fact, the experimenters themselves may have done, and encouraged, this--the machine was

designated as DAD (device for automated desensitization). Thus, that there are relationship factors in all counseling or psychotherapy is seldom denied. But most of those who recognize the presence, and importance, of the relationship view it as a nonspecific factor, as noted in Chapter 11. It is not considered as directly related to the client's problems or to their solution. It is considered as the general environment in which, or the base from which, the therapist operates, using specific methods or techniques. It may be viewed as rapport, or the method of inducing the client to develop trust in the therapist. This is essentially the view of behavior therapists.

There are two arguments against this view, and in favor of the position taken in this book that the relationship is the specific treatment element in psychotherapy:

1. If it is assumed, as is done here--and there is evidence for this as noted earlier (see Chapter I)--that the source of much if not most of the problems of clients involves interpersonal relationships, mainly the lack of or inadequacy of good human relationships--then a therapy that provides, and models, a good human relationship is a relevant and specific treatment method.

2. There is evidence that the relationship, without the addition of any techniques, is effective with many clients with many kinds of problems. This point will be considered later, and the evidence is presented in Chapter 13.

THE RELATIONSHIP: NECESSARY AND SUFFICIENT?

In addition to recognition of the relationship as a common element in all counseling or psychotherapy, there is widespread acceptance of its importance and even necessity. Goldstein, after reviewing the literature on therapist-patient expectancies in psychotherapy, concluded: "There can no longer be any doubt as to the primary status which must be accorded the therapeutic transaction." (6).

Menninger and Holzman, in *Theory of Psychoanalytic Techniques,* view the process of psychoanalysis as a two-person contractual relationship. (7) Goodstein, reviewing a collection of papers published under the title *What Makes Behavior Change Possible?* states that among virtually all the contributors there is an awareness of and attention to the therapeutic relationship as an essential ingredient of behavior change. (8) The fourteen contributors included Frank, Strupp, Burton' Ellis, Raimy, Polster, Bandura, and Wolpe.

Behaviorists recognize the presence of the relationship, though sometimes minimizing its importance. Observers of Wolpe and of Lazarus (when he was associated with Wolpe) noted that relationship variables were present. Lazarus acknowledged this in commenting on the report: "Both Wolpe and I have explicitly stated that relationship variables are often extremely important in behavior therapy. Factors such as warmth, empathy and authenticity are considered necessary but often insufficient. (9) Subsequently Wolpe insisted that "no basis exists for the idea that others have more compassion than behavior therapists. (10) More recently he wrote that "the more the

patient feels a responsive warmth towards the therapist, the more likely to be inhibited are those of his anxieties that are evident during the interview." (11)

The question of the presence and importance of the relationship in counseling or psychotherapy is thus not an issue nor, it would appear, is the question of its necessity. But there are few who would agree that the relationship is not only necessary but also sufficient.

A major implication of the model presented in Chapter 1 is that the relationship is not only necessary but sufficient for therapeutic behavior change. Note the adjective *therapeutic*. No one would deny that there are other ways to change behavior--force or threat of force, drugs, psychosurgery, brainwashing, and, to a very limited extent with human beings, conditioning. But for positive changes in voluntary clients, the conditions of a therapeutic relationship are sufficient for a wide variety of changes with a wide variety of problems. There may be limits, but if so it is not yet clear what these limits are. As the conditions are tested in more and more situations, without the addition of other specific methods or techniques such as interpretation or behavior modification techniques, they demonstrate their effectiveness. They work with all kinds of problems and all kinds of people--the poor and disadvantaged as well as the rich and middle-class. The problem with certain kinds of clients is not the ineffectiveness of the conditions but of implementing or communicating them. The conditions themselves are not time--nor culture--bound, as noted in Chapter 10.

The question of sufficiency involves the question: Sufficient for what? Rogers, (12) in his initial statement of the hypothesis of the necessary and sufficient conditions, used the term *therapeutic personality change.* This needs definition. In this book it has been argued that a relationship characterized by empathic understanding, respect, and therapeutic genuineness leads, in the client who perceives these conditions, to progress in self-actualization. It leads, in part, to the development of these characteristics themselves, which constitute elements of self-actualization.

But what about other outcomes? People often come to counselors or therapists with problems involving lack of information or knowledge, lack of skills of various kinds--deficiencies of a cognitive or motor nature. Surely where these are lacking or inadequate, the providing of a relationship is not sufficient. But it may be, and is here, argued that dealing with such problems would appear to be education (or reeducation) or teaching, rather than therapy. While it may be difficult to draw a line between therapy and (remedial) teaching, there would seem to be some value in doing so. One difference is that therapy is concerned with persons who are not lacking in knowledge or skills but are unable for some reason to use their knowledge or skills. Their problem, in the distinction made by many learning theorists, is not one of learning but of performance.

Therapy as a relationship is sufficient for enabling them to do those things that they are capable of doing. On the other hand, the relationship may not be sufficient where there is a lack or deficit. It is here that cognitive methods and techniques would be relevant and appropriate. To include these methods in counseling or psychotherapy simply because

clients want or need such approaches is to unduly extend therapy to cover educational methods and practices.

However, even here, two comments are in order. First, it is becoming increasingly recognized that learning is not simply a cognitive process, as Rogers and other writers on humanistic education have emphasized. (13) Cognitive therapists often appear to ignore or be unaware of this. Second, the teacher-student interaction involves a personal relationship, and evidence is accumulating that the same factors that lead to therapeutic personality change also facilitate cognitive learning. (14) In fact, in some teaching--perhaps the best teaching--creating a suitable relationship may be sufficient for some kinds of learning by some learners.

In addition, evidence is accumulating that a therapy relationship characterized by empathic understanding, respect, and therapeutic genuineness, *without the addition of other methods or techniques* such as direct instruction or remedial teaching or cognitive techniques, can lead to client changes in behavior beyond those represented by the conditions themselves. As noted in the model presented in Chapter 1, clients may engage in seeking information and skill training and other learning experiences on their own, perhaps as a by-product of becoming more self-actualizing persons.

In the light of research indicating that the conditions alone are sufficient for a wide variety of outcomes, it becomes difficult to determine when other methods or techniques or other kinds of help should be included. It would appear that a client who lacks information should be given the information, or that a client who possesses incorrect or false information should be provided with accurate information. On the other hand, client responsibility might be increased if clients were simply told where to obtain lacking or accurate information. Similarly, where skills are lacking, clients could be informed where they could obtain instruction. Certainly therapists do not, and could not, provide instruction in all the kinds of skills that might be lacking in their clients-or provide all the kinds of information that they could lack.

Not every client will improve in a relationship that includes the core conditions. There is, of course, the possibility that the therapist conditions are not present at high enough levels in some cases. Even the best therapists encounter clients with whom they cannot fully empathize, or whom they cannot respect, like, feel warm toward, or be highly genuine with. Then there is always the possibility that in spite of the therapist's offering of high levels of the conditions, as rated by an outside observer, the client does not perceive these conditions. It is difficult, and sometimes impossible, to break through to some clients. The nature of the disturbance in some clients--for example, paranoia--may prevent it. Some clients may be so defensive that they cannot perceive anyone as genuinely interested in them. Other clients may be too threatened to trust anyone or to enter a relationship even with the best therapist. In addition, it is possible that even though the conditions may be present, they may be nullified or rendered ineffective by other, inconsistent and negative, elements introduced in the relationship by the therapist. Some therapists, after establishing a relationship, may attempt to use it to manipulate, persuade, or guide the client, leading to client confusion or resistance.

An apparent reason for the wide variety of changes in clients who are provided a therapeutic relationship without direct instruction or specific training is found in one of the effects of the relationship conditions in the therapy process. The presence of the conditions leads the client to engage in the process of self-exploration. Clients learn to take responsibility for themselves when they are expected to and allowed to do so. They make necessary choices and decisions. They seek and obtain necessary information when it is lacking. They look for and obtain training in necessary or desirable skills.

Since therapy is effective without specific methods or techniques beyond the relationship itself with a wide variety of clients with a wide variety of problems, a number of questions arise. When is the relationship not sufficient? Since results are obtained without the use of information-giving, advice, suggestions, interpretations, persuasion, and so on, then it is clear that none of these is necessary. The question then is: Do these other techniques help when added to the relationship, without undesirable side effects? When do they help? And a final question, which has not been investigated: If the relationship is not only necessary but sufficient for so many outcomes, is it efficient? (15) Again, are there other methods or techniques that would increase the efficiency of therapy, when added to the relationship, in achieving the same outcomes, and again without other undesirable side effects?

NOTES

1. E. T. Gendlin. Client-centered developments in work with schizophrenics. *Journal of Consulting Psychology*, 1962, 9, 205-212.
2. C. R. Rogers, E. Gendlin, D. J. Kiesler, and C. B. Truax (Eds.). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison: University of Wisconsin, 1967.
3. D. A. Wexler and L. N. Rice (Eds.). *Innovations in client-centered therapy*. New York: Wiley, 1974.
4. For example, F. Alexander and T. French. *Psychoanalytic therapy.* New York: Ronald Press, 1946.
5. P. J. Lang, B. G. Melamed, and J. Hart. A psychophysical analysis of fear modification using an automated desensitization procedure. *Journal of Abnormal Psychology*, 1970, 76, 220-234.
6. P. Goldstein. *Therapist-patient expectancies in psychotherapy.* New York: Macmillan, 1962, p. 105.
7. K. A. Menninger and P. S. Holzman. *Theory of psychoanalytic techniques* (2nd ed.). New York: Basic Books, 1973. In describing psychoanalysis as a two-person contract, they note that in a business contract the relationship between the two parties is not important but that "in psychotherapy these relations are by no means incidental; they are the basic elements in the transaction" (p. 22).
8. L. D. Goodstein. Detente in psychotherapy. Review of A. Burton (Ed.), *What makes behavior change possible?* In *Contemporary Psychology*, 1977, 22, 578-579.

9. M. Klein, A. J. Dittman, M. B. Parloff, and M. M. Gill. Behavior therapy: Observations and reflections. (With comment by A. Lazarus.) *Journal of Consulting and Clinical Psychology*, 1969, 33, p. 262.
10. J. Wolpe. *The practice of behavior therapy* (2nd ed.). New York: Pergamon Press, 1973, p. 9.
11. In A. Burton (Ed.), *What makes behavior change possible?* New York: Brunner/Mazel, 1976, p. 66.
12. C. R. Rogers. The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 1957, 21, 95-103.
13. C. R. Rogers. *Freedom to learn.* Columbus, OH: Merrill, 1969; C. H. Patterson. *Humanistic education.* Englewood Cliffs, NJ: Prentice-Hall, 1973; C. H. Patterson. *Foundations for a theory of instruction and educational psychology.* New York: Harper & Row, 1977.
14. D. N. Aspy. *Toward a technology for humanizing education*. Champaign, IL: Research Press, 1972.
15. Albert Ellis has recently addressed this question in A. Ellis, The value of efficiency in psychotherapy. *Psychotherapy: Theory, Research and Practice,* 1980, 17, 414-419.