

5

CLIENT-CENTERED THERAPY: THE EVOLUTION OF A REVOLUTION

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The purpose of this chapter is to review research in client-centered therapy (CCT). Our review reveals that research in CCT has played a seminal role in the investigations of psychotherapy and is integrally intertwined with outcome research in psychotherapy. Research of psychotherapy outcome suggests that the most viable treatment is emergent, determined, and acted on by the client and facilitated by the centrality of the client–therapist relationship and client’s resources. This is the primary intention and focus of CCT. Four distinct periods characterize the research associated with CCT: (a) nondirective therapy (1940–1951), (b) the client-centered relationship (1951–1957), (c) conditions of therapy (1957–1987), and (d) common factors revisited (1987–1999).

Carl R. Rogers revolutionized the field of psychotherapy and counseling. He did this by proposing a theory that focused on the client as the agent for self-change. Rogers’s (1951, 1959) theory of humans in the process of actualization was embraced by humanistic psychology. Rogers’s stance, however, was more radical than most other humanistic schools of psychotherapy. Rogers emphasized the client and client resources as the focus of the theory and the client–therapist relationship as the healing catalyst. Rogers’s radical view that the clients are always their own best experts about their lives differed from most other schools of psychotherapy, including other humanistic schools.

Rogers also altered the face of psychotherapy by initiating scientific research of psychotherapy process and outcome. He and his colleagues were

We are indebted to the editorial and conceptual contributions of Kathy Moon and Amy Shenkel.

the first to examine audio recordings of therapy sessions to determine what actually took place in therapy. They examined therapy outcome through the hard criteria of behavioral improvement and clinical assessment using quantitative research designs. As such, the demystification of psychotherapy began.

THE FIRST PERIOD: NONDIRECTIVE THERAPY (1940–1951)

This period was characterized by Rogers's belief that rapport with and acceptance by the therapist facilitated the client's own acceptance of self. Rogerian therapy underscored the idea that the client, rather than the therapist, was the director of the treatment. This approach was labeled *nondirective*. Research during this period was directed toward investigations of nondirective therapy.

This period included the first major efforts to explore psychotherapy through quantitative research designs. Previous qualitative studies, which provided detailed examination of therapy sessions by means of audio recordings, were now extended to include quantitative studies.

In *Counseling and Psychotherapy*, Rogers (1942) accentuated his intention of operating within the scientific paradigm. He made predictions about therapeutic change and used hypothesis tests. His initial hypothesis was that if therapists accept, recognize, and clarify the feelings expressed by the clients, then there will be movement from negative to positive feelings, followed by insight and positive actions initiated by the clients. In describing his hypothesis, Rogers emphasized three aspects of the therapist's role: (a) the importance of responding to expressed feelings rather than to content, (b) the acceptance of the client's feelings by the therapist, and (c) the clarification of the client's expressed feelings. These hypotheses could be examined with detailed scrutiny through the newly discovered media of audio recordings. The first step of quantitative research on psychotherapy sessions was set through analysis of the verbal interchange between clients and therapists.

Directive and Nondirective

One area of investigation was to describe therapist and client discourse and their interactions. Initial interest was in the therapist and whether nondirective therapists were different from other therapists. Porter (1943) found that judges were able to reliably differentiate verbal classifications between counselors on a directive–nondirective continuum. The same method was applied a year later by Gump (1944) to client-centered and psychoanalytic recordings with similar results.

Snyder (1945) studied both client and therapist verbal behaviors in 48 interviews from six different cases, five of which were considered successful. He found nondirective therapists to be consistently nondirective. Analysis showed movement in the client from early to late interviews in such areas as emergence of understanding or insight, increased planning activity, and positive feelings. These findings supported Rogers's predictions and served as a springboard for further research.

Interaction of Client and Counselor

Bergman's (1950) study of the interaction of client and counselor responses is indicative of findings in this area. Using category systems, Bergman found that structuring or interpretive counselor statements were followed by clients' abandonment of self-exploration, whereas counselor responses that were classified as reflecting feeling were followed by clients' continual self-exploration or insight. Snyder (1945) found that nondirective responses by therapists were more likely to be followed by clearer statements of problems by clients.

The supplementation of findings of quantitative studies were also supported by qualitative studies. For example, qualitative observations by Snyder (1947) revealed that clarification of the client's feelings created experiences of self-acceptance.

Relationships of Attitudes Between Self and Others as Affected by Therapy

In a series of coordinated research identified as the Parallel Studies Project that occupied an entire issue of the *Journal of Consulting Psychology* (Raskin, 1949), several methods and questions were applied to 10 completely recorded cases. Quantitative and qualitative studies were included in this coordinated research project.

In a replication of Snyder's (1945) study with these 10 cases, Seeman (1949) discovered that 85% of the therapists' behaviors were nondirective, compared with 63% for the therapists in Snyder's cases. In the same project, Sheerer (1949) devised categories to record acceptance of self and others. Judges reliably recorded client statements and tested for an increase in the acceptance of self and subsequent acceptance of others. On the basis of her findings, Sheerer (1949) concluded that the individual's evaluation of others plus the degree of acceptance and respect are significantly related to attitudes toward self (p. 175). Stock (1949) found a correlation between the way that clients feel about themselves and others. Hoffman (1949) investigated the growth of maturity in clients as therapy progressed. Maturity was defined as whether the client was behaving with little or no control over himself

or herself or the environment, and behaving with substantial self-direction and responsibility. Ten cases were divided into a successful group and an unsuccessful group. Successful clients significantly improved in maturity, whereas the 5 least successful clients did not improve.

Self-Reference and Client–Therapist Relationship

Raimy (1948) concluded that self-concept changed as a result of therapy. Cases judged successful showed positive change in self-concept. Unsuccessful cases did not show such change.

The research during this period therefore identified nondirective therapy as related to increased understanding, more positive feelings, greater self-exploration, improved self-concepts, and improved maturity of clients. Nondirective therapy was found to be as effective but not more effective than Adlerian therapies in one dissertation. Another dissertation (Heine, 1953) and a later journal article (Shlien, Mosak, & Dreikurs, 1962) buttressed this finding. These studies were forerunners to the pervasive conclusion of decades of therapy research that outcome is related to common factors rather than to particular therapies (Hubble, Duncan, & Miller, 1999; see also The Fourth Period, below). One key contribution of research during this period lay in the demonstration that the methods of science could be successfully brought to bear on the data of therapy.

THE SECOND PERIOD: THE CLIENT-CENTERED RELATIONSHIP (1951–1957)

For Rogers, in this period, the basic motivating force of the individual was freed when the therapist assumed the internal frame of reference of the client. Rogers shifted from emphasizing clarification of the client's feelings to emphasizing broader understanding of the way in which the client views the world. Research focused on the individual's frame of reference that ranged from self-concept studies to effectiveness studies. Coordinated research and more rigorous and extensive research designs were also developed during this period.

This period began with publication of *Client-Centered Therapy* (Rogers, 1951). In this book, Rogers emphasized that the therapist's attitude, rather than any particular technique, was central to successful therapy. Rogers extended his belief that individuals possess an innate, fundamental motivating inner force for change toward increased self-actualization. The foundation of the theory was clarified with the postulate that the client knows best the problems and the direction to take. The investigation of this hypothesis was undertaken from the following perspectives.

Central Importance Given to the World of the Client

In this period, there was increased emphasis on the importance of the client's world as the client views it. CCT was not to be viewed as a problem-centered therapy. Rather, it was centered on personality change that then enabled clients to solve problems and to more successfully engage new problems. Research moved toward investigating hypotheses related to the centrality of the client as a person.

Using Q-Sort instrumentation, Heine (1953) asked clients of psychoanalytic, nondirective, and Adlerian therapists to describe changes they experienced and to identify their reasons for the changes. Regardless of therapy orientation, the clients reported similar changes. When clients of psychoanalytic therapists reported their reasons for change, they tended to focus on therapist technique, whereas clients of nondirective therapists tended to attribute change to qualities of the therapeutic atmosphere.

Several studies were reported in detail in *Psychotherapy and Personality Change* (Rogers & Dymond, 1954). The book reports one of the first coordinated series of controlled research projects designed to assess changes in psychotherapy. Clients were placed into a therapy group and a *wait-list* or *own control* group. The second group deferred the beginning of therapy for 60 days. In addition, two comparable groups were formed as *equivalent control* groups. Measures used included counselor ratings, projective tests (scored by independent diagnosticians), independent observer judgments, and self-reports. The self-report instruments were primarily based on the methods of Stephenson (1953), which were further developed by Butler and Haigh (1954). Multiple outcome measures were administered, and the interrelationship of outcomes was assessed. The first group of studies was concerned with client changes in self-perception. Does therapy result in a change in self-perceptions so clients may view themselves as being more like their ideal? With Q-Sort measurement methodology, the results indicated that the relationship of the client group before therapy was low and increased significantly in relation to the control group after therapy. To investigate the change in the self and ideal self, Rogers and Dymond (1954) selected a subpopulation as improved on the combined basis of the Thematic Apperception Test diagnostic rating and counselor judgments. The clients who were more improved on both measures were less discrepant between self and ideal self.

Although this was a bold venture in research design during this period, there was one scathing critique of the coordinated studies project (Meltzoff & Kornreich, 1970). Meltzoff and Kornreich suggested that the studies provided little tangible evidence about the efficacy of psychotherapy because of the lack of a randomly assigned control group, reliance of self-report data, and the presence of biased samples. They cited the most crucial flaw in the

design as the lack of a randomly assigned control group. Although technically a viable argument, the valence of the argument has become a moot point. The fact is that there have been few studies in the 45 years of psychotherapy outcome research following this series of studies that meet this criteria. Their critique of self-report data reflects their own bias. Viable data and self-report data have become increasingly accepted even by advocates of true design research.

Transitions to Common Conditions Research

One of the first studies to look for common conditions related to successful therapy was conducted at Johns Hopkins Hospital in Baltimore, Maryland. Whitehorn and Betz (1954) conducted a retrospective study that compared the interpersonal manner of 7 successful psychiatrists with 7 similarly trained, unsuccessful psychiatrists in their work with patients with schizophrenia. The successful psychiatrists had an improvement rate of 75%, whereas the unsuccessful psychiatrists had an improvement rate of only 27%. The evidence indicated that the successful therapists were warm and attempted to understand the subjective, phenomenological experiences of their patients. In contrast, less-successful therapists related to their patients in a more impersonal manner, focusing on matters other than patients' experiences, such as symptoms of pathology. This was one of the first studies that did not involve therapists who were identified as client centered.

In summary, most of the therapists in the studies were client-centered therapists. Most of the studies examined some aspect of client-centered theory, and most of the designs were among the first attempts for sophisticated scientific method research. Although the designs could be critiqued on the criterion of the true design research model, this critique can be made of most designs since that time. As Rogers (Rogers & Dymond, 1954) indicated, the research in the coordinated study was not good research. Rather, it was the best there was at the time. Ironically, it turns out that the research of this period was just as rigorous as most of the psychotherapy outcome research over the next 4 decades.

Successful CCT was found to increase self-acceptance and personal worth of clients. Comparisons with other therapies, particularly Adlerian therapy, found comparable outcome results. The research started to expand to examination of common therapist factors regardless of theoretical orientation.

THIRD PERIOD: CONDITIONS OF THERAPY (1957–1987)

This period was characterized by a shift of research emphasis from examining CCT to examining attitudinal conditions of therapists of all

persuasions. In an article titled "The Necessary and Sufficient Conditions of Therapeutic Personality Change," Rogers (1957) set forth a hypothesis that evoked more than 3 decades of research. This was a landmark proposal for CCT, for psychotherapy, and for helping relationships in general. The core of the article was two-pronged. First, the conditions postulated by Rogers became the central intention for client-centered therapists (Rogers, 1959). Second, these conditions are postulated to be essential for all theories of therapy and for all helping relationships that involve therapeutic personality change as a goal. This is postulated even when other theories focus on other central issues. Rogers's (1957) article has been dubbed the "integration statement" (Bozarth, 1998; Stubbs & Bozarth, 1996) and the "conditions of therapy theory" (Barrett-Lennard, 1998). The conditions described by Rogers (1957) are the following:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, which 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.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (p. 96)

Rogers's (1957) definitions of the three therapist attitudes are the following:

Congruency (or genuineness) is the state of the therapist during the therapy session where "within the relationship (the therapist) is freely and deeply himself, with his actual experience accurately represented by his awareness of himself . . . [and] . . . the therapist is what he actually is, in this moment of time."

Unconditional Positive Regard is "the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client."

Empathic Understanding is "To sense the client's private world as if it were your own, but without ever losing the "as if" quality."(pp. 97-99)

Rogers hypothesized that these conditions were both necessary and sufficient for the initiation of a process of constructive personality change. By "necessary," he meant that constructive personality change would not

take place if any of these conditions were not present. By “sufficient,” he meant that these conditions were adequate for constructive change to occur.

Much of the outcome research involving CCT shifted from inquiry regarding the differences among therapies toward examination of therapist attitudes. Samples of therapists in most published studies after Rogers’s (1957) integrative statement are not client-centered therapists (Bozarth, 1983). Most of the research that was considered to be client centered actually focused on attitudinal conditions regardless of therapists’ theoretical persuasions.

A Core of Studies

Contributions by Halkides (1958) and Barrett-Lennard (1962) led the way for additional measurement developments (Rogers, Gendlin, Kiesler, & Truax, 1967; Truax & Carkhuff, 1967). Halkides devised scales for ratings by judges on audiotapes of the conditions. She also found that the three conditions were related to successful cases. Barrett-Lennard (1962) developed the Relationship Inventory, which assessed clients’ perceptions of the conditions. Barrett-Lennard found that clients improved to the extent that they perceived their therapists as understanding, congruent, positive, and having unconditional regard for them. The Relationship Inventory, which was developed to measure the client’s perception of the relationship, has been validated and improved over the years (Barrett-Lennard, 1998). It has also been used in research all over the world and translated into more than 15 languages (Barrett-Lennard, 1999).

Other studies were reported in areas outside of psychotherapy outcome research. For example, one study (Gaylin, 1966) demonstrated change in creativity variables after 20 sessions of CCT.

From 1957 to 1963, Rogers and his colleagues at the University of Wisconsin undertook the daunting task of studying the client-centered approach in psychoses. Although the overall results revealed few significant differences as reported elsewhere (see Prouty, this volume, chapter 19), several studies (Barrett-Lennard, 1999; Truax & Mitchell, 1971; van der veen, 1965, 1967, 1970), using the original Wisconsin data, found various outcome measures positively associated with the core attitudes. The direction of client-centered research was influenced in several ways. First, the Wisconsin project was Rogers’s last major quantitative research project. Second, coordinated efforts to research CCT virtually disappeared in the United States after this project. Third, the “therapist-offered conditions” were perpetuated as a viable research endeavor for psychotherapy outcome. Fourth, scales used became the mainstay for later development of interpersonal skills training programs and for continued research (Bozarth, 1998). Fifth, the

data revealed that “successful” clients perceived higher conditions of congruence and empathy in their therapists, whereas clients who deteriorated perceived lower conditions (Rogers et al., 1967). The Wisconsin project, identified by some as a failure because of the overall lack of significant findings (see Prouty, this volume, chapter 19), added substance and direction to research of the necessary and sufficient conditions in psychotherapy outcome.

Lietaer (1988, 1990) and Bozarth (1983) concluded that CCT research in the United States during the 1970s and 1980s was limited in volume and shrinking with the passing years. Bozarth concluded that this was, in part, due to the fact that most sampled therapists were not client-centered therapists (a fact that continues throughout research in the United States). Bergin (1971) identified eight selected studies on client-centered psychotherapy from 1957 to 1967, including the Wisconsin study (Rogers et al., 1967), and another four studies with control groups from 1954 to 1965, including Rogers and Dymond’s (1954) study. By the time of the second edition of the *Handbook of Psychotherapy and Behavior Change* (Garfield & Bergin, 1978), the chapters on evaluation of therapeutic outcomes (Bergin & Lambert, 1978) and on therapist variables related to process and outcome (Parloff, Waskow, & Wolfe, 1978) had little discussion about CCT. Likewise, later reviews (Bergin & Garfield, 1994; Garfield & Bergin, 1986) revealed few studies on CCT. Outcome studies on CCT were reported in some theses and dissertations at this time, but most were not published in the professional literature. Lietaer noted the increasing diversity and divergence from Rogers’s theory. Specifically, he identified the thrust of the works of Wexler and Rice (1974), Gendlin (1973), Carkhuff (1972), and Gordon (1970) as examples of such diversity and divergence. Two of these directional thrusts are considered elsewhere (see this volume, Hendricks, chapter 7; Greenberg, Korman, & Paivio, chapter 16). Studies of training models identified as human relations and interpersonal skills models are not included in this review. Most of these models were developed from Rogers’s (1957) hypothesis of the necessary and sufficient conditions and were perpetuated by the training proposals of Truax and Carkhuff (1967). Their review of research supported the notion that the conditions cited by Rogers resulted in constructive personality change in a wide variety of clients, “including college underachievers, juvenile delinquents, hospitalized schizophrenics, college counselees, mild to severe neurotics, and the mixed variety of hospitalized patients” (p. 100). Many of their references are reported in a later review of psychotherapy outcome research (Truax & Mitchell, 1971). Some of their major references are cited throughout the present chapter. Truax and Carkhuff proposed training methods that might promote these core conditions of therapists. Other publications then deviated from Rogers’s

TABLE 5.1
Research on Client-Centered Therapy in Germany

Author	Population/Focus	Design	Results
i-1. Rudolph, Langer, and Tausch (1980)	Clients of psychotherapeutic ambulance Psychological Institute III, University of Hamburg; higher scores in neuroticism and introversion, psychasthenia, and anxiety (MMPI), 37% with psychosomatic complaints, 36% sexual difficulties, 45% work difficulties.	149 clients (37 first waiting 17 weeks + control group); 80 client-centered therapists, with 50% little experience. Average of 11 sessions during 17 weeks. Every client had 2 therapists. After 4 sessions, the client could choose only one therapist; 75% chose the more experienced therapist.	Significant positive changes in test scores and problem lists. This was related to high end of at least 2 of Rogers's 3 dimensions of therapists (rated by tapes and by clients). Changes were not dependent on kind and degree of disturbances or test characteristics; 44% variance of changes predictable by client ratings of therapists after 4 sessions.
i-2. Bormert, Minsel, Fitkau, Langer, and Tausch (1972)	Clients of psychotherapeutic ambulance Psychological Institute III, University of Hamburg; higher scores in subtests of EPI and MMPI.	44 clients (22 first waiting 9 weeks + control group); 13 psychotherapists (psychologists). Average 6 psychotherapeutic sessions during 8-9 weeks.	Significant positive changes on MMPI and scales of EPI. Empathy of therapists (related by clients) correlated .44 with positive changes in neuroticism and introversion, regard of therapist with self-rated changes of clients, self-exploration of clients correlated with positive changes in anxiety (MMPI).
i-3. Minsel et al. (1972)	Clients (mostly students) asking for psychotherapeutic help.	55 clients (20 first waiting 9 weeks + control group); 19 psychotherapists (psychologists). Average 6 psychotherapeutic sessions during 8-9 weeks.	Significant positive changes on MMPI and on Eysenck Personality Inventory (EPI). Self-exploration of clients (rated by tapes) correlated significantly with positive changes in neuroticism and extroversion and with empathy of therapists (tape rated).
i-4. Doll et al. (1974)	Male prisoners with striking disturbances on Eysenck Personality Inventory and Personal Orientation Inventory.	25 prisoners received 6 therapeutic sessions by telephone (30 min); 6 client-centered therapists (control group, 36 prisoners).	Increase in self-acceptance and decrease in tendency to lie. Those who had all sessions compared with less than 6 sessions showed decrease in psychoneuroticism and decrease in aggressiveness.

- I-5. Ronnecke et al. (1976)
- Elderly, mean age 74 years, living alone, low income, with help from state administration. Offered 8 psychotherapeutic telephone sessions (30 min during 8 weeks).
- 24 elderly women in therapy group, compared with 29 in waiting group, 17 client-centered psychologists.
- Life satisfaction of those talking with psychologists was significantly increased. After 8 telephone sessions and 8 weeks later, 65% elderly women reported positive changes in many important areas of their daily lives.
- I-6. A. M. Tausch, Kettner, Steinbach, and Tönnies (1973)
- Therapy group = 29 disadvantaged kindergarten children and 30 disadvantaged pupils (mean age = 8.3 years). Control group = 28 disadvantaged children and 19 pupils.
- 7 weeks individual client-centered therapy (10 min weekly) and group therapy (2-5 children; 30 min weekly) by 5 client-centered therapists. Before and after therapy various tests, interviews with 1-2 adults and ratings from teachers.
- Compared with control groups, counseled children/pupils showed significant positive changes in emotional stability, social cooperation, verbal spontaneity, and perceptual accuracy in intelligence tests. Self-exploration of pupils correlated with accurate empathic understanding and positive regard by psychologists.
- II-1. Boeck-Singelmann, Schwab, and Tönnies (1992)
- Clients of psychotherapeutic Psychological Institute III, University of Hamburg. Mean age 30 years, unfavorable test scores in depression, nervousness (EPI), and in Tennessee Self-Concept Scale. 65% clients had body complaints, 46% took medicine regularly, 13% high alcohol consumption.
- 53 clients (19 first waiting 4 months + control group); 55 client-centered therapists. Every client had 2 therapists in every session (a woman and a man), always 1 experienced and 1 student therapist.
- Therapy clients had significant, positive changes in self-concept and in psychosomatic complaints. No significant changes in waiting group. In global self-rating of clients (Strupp), 67% of clients were satisfied with therapy, and 90% saw the therapy as important and helpful. 17 clients could be reached by mail 1 year. The improvement was stable: 85% held the presence of the 2 therapists in the sessions as favorable. Arguments: Men and women, more independence from only one therapist, supplementation of therapists. The majority of the therapists perceived team therapy as good possibility for learning. The groups of more improved clients perceived the experienced therapist as significantly more empathic and contruent than the group with small or no improvement.

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TABLE 5.1
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Author	Population/Focus	Design	Results
II-2. Schaefer (1992)	Clients of psychotherapeutic Psychological Institute III, University of Hamburg. Mean age 35 years, no students. Unfavorable test scores: 71% complaints in partnership, 51% in work, 39% family. Focus: Can the outcome of therapy be made better through organizational conditions?	86 clients in therapy group and 27 in waiting control group; 17 experienced and 86 learning therapists. I. Every client had after 5 and 10 sessions an interview for clarification with an outside psychologist. Half of therapy group had 2 therapists (team therapy). Other half of therapy group could choose between 2 therapists teams.	I. The clarification speeches with a psychologist had very good effects, especially by clients with slow progress and little satisfaction with the therapy. II. The possibility to choose between 2 therapist's teams had good effects regarding dropout (7% vs. 32% without the possibility) and also on the outcome: 64% who could choose were markedly improved vs. 36% of those who could not choose.
II-3. Tausch (1988)	Transcripts of psychotherapeutic sessions of Carl Rogers, David Burns, and Wilhelm Gerl, a focusing therapist. To what extent do these therapists focus on cognitions and emotions?	Therapists and their clients' utterances were separately rated for the amount of cognitions and emotions on 5-point scales.	Carl Rogers: mean in every utterance, 3.3 for cognitions, 2.3 emotions. David Burns: 4.3 for cognitions, 1.5 emotions. Wilhelm Gerl: 1.7 for cognitions, 2.8 emotions (focusing therapist). In 67% of his responses, Rogers attended more to the clients' cognitions than emotions; in 25%, this was equal, and in 19%, more emotions than cognitions. In 65% of the following utterances, his clients expressed more cognitions than emotions; in 25%, equal; and in 19%, more emotions than cognitions. A high level of empathy for the clients' cognitions and emotions was present in 23% of Rogers's responses, 8% of Burn's responses, and 5% of Gerl's responses. These facts can correct misunderstanding of the term <i>feelings</i> in client-centered therapy.

II-4. Eckert, Schwartz, and Tausch (1977)

Clients of psychotherapeutic Psychological Institute III, University of Hamburg. Purpose of research: What are the experiences and emotions of clients during the psychotherapeutic session? Are they predicting the outcome of the therapy?

25 clients with clear positive changes after therapy and 25 clients with only few changes, elected from a total of 97 clients with 80 client-centered therapists (Rudolph et al., 1980). Both extreme groups did not differ in test scores by the beginning of the therapy. Clients marked their experiences on 14 items after each session. The behavior of clients and therapists was rated by tapes.

The experiences of positive and negative extreme groups of clients differed drastically. (Also in the first session, the positive group had clearly more favorable experiences.) Clients with positive changes saw their problems in a new light, felt themselves in the session more relaxed, and were more optimistic. The cognitions changed more in the beginning sessions, later the emotional experiences. Self-exploration of the clients (rated by tapes) had a correlation of .53 with changing perceptions and cognitions. Deep emotional engagement of the clients (rated by tapes) correlated with satisfying experiences. Empathy, activity, and concreteness of therapists (rated by tapes) correlated (.49-.56) with clients' satisfaction with the session.

II-5. Sander, Tausch, Bastine, and Nagel (1969)

Clients of psychotherapeutic Psychological Institute III, University of Hamburg, asking for therapeutic help. Focus: Is empathy of therapist a main condition for self-exploration of client?

12 clients; 4 client-centered therapists. The therapists diminished their empathy for 10 min. Rating of tapes in empathy and self-exploration before, during, and after the diminished empathy.

The significantly diminished empathy of therapists was connected with significantly diminished self-exploration. The normal high empathy of therapists was connected with the amount of self-exploration as before the experimental phase. High empathy (measured by tapes with the Truax scale) can be seen as a main condition for high self-exploration and therefore for chances of favorable outcome.

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TABLE 5.1
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Author	Population/Focus	Design	Results
II-6. Fox and Tausch (1983)	120 adults, ages 18-50 years, 53% married, 45% workers and employees, without asking for help. Focus: Proof of Rogers's hypothesis that the 3 core conditions of therapy are also core conditions of helpful relationship in other areas (here in partnerships).	The adults filled out questionnaires on how they perceived their partners and about their satisfaction in various areas of partnership/marriage.	With the partnership, satisfied persons ($n = 60$, median) vs. unsatisfied persons ($n = 60$, median) perceived their partner favorable in empathy 90% (vs. unsatisfied persons, 27%); in regard-caring, 98% vs. 68%; in nondirectivity, 97% vs. 67%; and in helpful activities, 100% vs. 58%. More striking were the differences between satisfied and unsatisfied persons in percentage of very favorable perception: empathy, 28% vs. 2%; regard-caring, 75% vs. 10%; and helpful activities, 45% vs. 7%.
II-7. Caspari and Tausch (1979)	416 adults not seeking therapeutic help. Focus: Is there a connection between facade-genuineness in daily behavior and psychic discomfort.	416 adults filled out a scale with items for facade-genuineness in daily behavior and other psychological tests.	Facade (vs. genuineness) in daily behavior correlated significantly with depression (.56), neuroticism (.49), and nervousness (.44). There was also a correlation between amount of facade and perceptions of the behavior of parents as cold, incongruent, and authoritarian (.22).

Note. I = outcome research; II = process-outcome research and related questions; EPI = Eysenck Personality Inventory; MMPI = Minnesota Multiphasic Personality Inventory.

primary assumptions of client authority and client direction (Carkhuff, 1967, 1969; Egan, 1975; Gordon, 1970, 1976; Gordon & Burch, 1974; Guerney, 1977).

Representative Research Outside of the United States

Lietaer (1990) suggested that contributions to the psychological literature on CCT were increasing in Germany (e.g., Helm, 1980; R. Tausch & Tausch, 1981), the Netherlands, and Belgium (Lietaer, van Praag, & Swildens, 1984; Van Balen, Leijssen, & Lietaer, 1986) in contrast to the lesser increase in the United States. Literature included clinical reports and research studies in group therapy with clinical populations as well as individual therapy.

Studies of person-centered group therapy with clinical populations are reported in the chapter on humanistic group research (see Page, Weiss, & Lietaer, this volume, chapter 11). Page et al. present nine European reports and another 12 studies as well as the results of two reviews of additional studies on person-centered clinical groups. Barrett-Lennard (1998) reported in detail research on client-centered group therapy, as did R. Tausch and Tausch (1990, 1998). Nearly all of these studies reveal positive results favoring the effectiveness of CCT and *conditions therapy theory* related to group psychotherapy.

Individual therapy fared as well in a cluster of studies supervised by Reinhard Tausch (see Table 5.1). The studies are well designed and, for the most part, incorporate large numbers of clients of diverse diagnoses, control groups, and a large number of client-centered therapists.

A study with 149 clients and 80 client-centered therapists and wait-list control clients (Rudolph, Langer, & Tausch, 1980) found that the person-centered psychotherapists who exhibited high levels of two of the three conditions of empathy, warmth, and genuineness had clients with positive changes. The presence of high levels of only one condition was associated with no or unfavorable change. This point reflects Rogers's (1957, 1959) hypothesis that more than one condition is necessary for client change. Additional findings in this particular study are of interest. They include the following: (a) Client changes were not dependent on the kind of disturbances or extent of test characteristics, (b) clients who quit therapy did so largely because of the unfavorable conditions of their therapists, and (3) client change could be predicted after the fourth contact by perceptions of the therapist and of client feelings about sessions.

Eckert, Schwartz, and Tausch (1977) recorded the self-reported experiences of clients after each of nine sessions with client-centered therapists. The favorable experiences of clients who were considered "more changed" differed considerably from those who "hardly changed."

The former clients revealed greater depth of self-exploration and perceived more empathic understanding from their psychotherapists.

Ronnecke et al. (1976) conducted a study of client-centered psychologists involved in telephone sessions with older people and found positive psychological change. Life satisfaction and attitudes of elderly people toward death and dying were examined. Findings included significant increases in life satisfaction after speaking with psychologists and improved psychological change after receiving counseling. The most helpful talking conditions were from helpers who had average levels of empathy and were involved in their own self-exploration. Likewise, Doll et al.'s (1974) study of prison inmates who received telephone counseling revealed that striking psychological disturbances could be helped by client-centered counseling. Different telephone research (Parikh, Steinbach, Tausch, & Teegen, 1973) involved the assessment of counselor helpers who commented on standardized counseling problems. Voice and speech samples were evaluated by 50 evaluators and by clients in a day clinic. Results revealed that assessment of speech quality by both groups showed a preference for voice quality that encouraged acceptance and that presented clear statements.

Other studies of individual therapy found the following: (a) Psychoneurotic clients in the experimental group showed significant reduction on psychoneuroses and introversion tests over the wait-list control group ($N = 81$; Minsel et al., 1972). (b) Psychoneurotic clients in the experimental group who received an average of six contacts with 1 of 13 client-centered therapists showed significant positive change over the no-treatment control group ($N = 42$; Bommert, Minsel, Fittkau, Langer, & Tausch, 1972). (c) Psychoneurotic clients ($N = 12$) exposed to a 10-minute reduction in accurate empathy showed significantly reduced self-exploration and an increase in cursory talk. Resumption of empathy was accompanied by a return of client's self-exploration (Sander, Tausch, Bastine, & Nagel, 1969).

Throughout this period, the studies by Tausch and his colleagues as well as others in Europe are quite positive. Positive findings are consistent in the areas of individual psychotherapy (see Table 5.1); group psychotherapy; and groups with cancer patients, prisoners, judges, teachers, and geriatric individuals. The findings extend to encounter groups, education, and daily life activities (Bergeest, Steinbach, & Tausch, 1977; Boeck-Singelman, Shwab, & Tönnies, 1992; Caspari & Tausch, 1979; Fox & Tausch, 1983; A. M. Tausch, Kettner, Steinbach, & Tönnies, 1973; R. Tausch, 1978). The studies include large samples of person-centered therapists, a rarity in the majority of later research in the United States.

An Analysis of the Research

An analysis of the research in psychotherapy outcome was undertaken to search for pronounced patterns of research during separate units of time. Using symbolic interactionism (Blumer, 1969) and constant comparative analysis (Glaser & Strauss, 1967), Stubbs and Bozarth (1994) discovered five categories of research focus from 1950 to 1993. These categories reveal the permeating influence of the Rogerian hypothesis on research in psychotherapy effectiveness. They also reveal a discordant connection between research results and the direction of outcome research over the years. This discordant connection resulted in the suppression of the research results supporting Rogers's hypothesis of the necessary and sufficient conditions. We discuss the categorical analysis below.

1. *Psychotherapy is no more effective than no psychotherapy* (1950s and 1960s; Eysenck, 1952, 1966). Eysenck's hypothesis that psychotherapy is no more effective than no psychotherapy stimulated considerable reaction and criticism (Bergin, 1971; Fay & Lazarus, 1992; Rosenweig, 1954). The general conclusions of research in this category suggested that psychotherapy is more effective than no psychotherapy. Somewhat unheralded and unrealized, the research on Rogers's hypothesis of the necessary and sufficient conditions became an important part of the responses to Eysenck. This is elaborated in Category 3.
2. *The core conditions (empathic understanding, unconditional positive regard, and congruence) are necessary and sufficient for therapeutic personality change* (1960s and 1970s). The research on this hypothesis was consistently supported (Lambert, DeJulio, & Stein, 1978; Truax & Mitchell, 1971) and continued to be supported through the late 1970s and the 1980s (e.g., Orlinsky & Howard, 1986; Patterson, 1984) in the face of more equivocal reviews to be noted later. Studies and reviews continued to support Rogers's hypothesis during this time. Truax and Mitchell (1971) presented 14 studies (8 of which were individual therapy) consisting of 992 participants. They identified 125 specific outcome measures favoring the hypothesis (66 of 158 were statistically significant). They report an analysis of the long-term effects of higher and lower levels of empathy, warmth, and genuineness experienced by the clients of the Wisconsin project (Truax & Mitchell, 1971, p. 329). Their data over 9 years indicate that hospital patients seen

by therapists low on the conditions tended not to get out of the hospital and that clients of these same therapists who did get out tended to return.

Lambert, Shapiro, and Bergin (1986) concluded that the attitudinal qualities “seem to make up a significant portion of the effective ingredients of psychotherapy” (p. 202). Orlinsky and Howard (1986) concluded their review of the research on the attitudinal conditions by stating that “generally, 50 to 80 per cent of the substantial number of studies in this area were significantly positive, indicating that these dimensions were very consistently related to patient outcome” (p. 365).

The series of studies in Germany by Tausch and colleagues (R. Tausch, 1990) as well as other studies in Europe provide additional strong support for Rogers’s hypothesis of conditions therapy theory. (See Table 5.1 and previous narrative review.)

Miller, Taylor, and West (1980) studied the effects of focused versus broad-spectrum behavioral therapy with problem drinkers in an effort to control their alcohol consumption. They collected data on therapist empathy as a secondary inquiry and found that the level of therapist empathy was highly correlated (.82) with outcome. Another example of the importance of relationship variables was the more recent study by the National Institute of Mental Health, which was conducted to compare various treatments for depression (Blatt, Zuroff, Quinlan, & Pilkonis, 1996). Blatt et al. compared the effects of the administration of a drug (imipramine), cognitive-behavioral therapy (CBT), interpersonal therapy, and “ward management,” which served as a placebo. The placebo effect involved a therapist who spent time talking to patients about ward management. There were no significant differences between the effects of the three active treatments. The best prediction of success at the end of any of the active treatments was whether the patient perceived the therapist as empathic at the end of the second interview. Drug treatment was significantly more successful if the patient viewed the therapist as empathic after the second interview.

Research supported Rogers’s postulates on the necessary and sufficient conditions with a wealth of studies. Such overwhelming evidence would suggest that further investigation be continued. This was not, however, the case.

3. *Psychotherapy is for better or for worse* (early 1960s). Somewhat unheralded and unrealized, the research on Rogers’s hypothesis of the necessary and sufficient conditions became an important

part of the responses to Eysenck (1952, 1966). Several reviewers pointed to the adverse effects of some therapists. Truax and Carkhuff (1967) concluded that psychotherapy was “for better or for worse” (p. 143). The review by Truax and Mitchell (1971) included a call for attrition in the ranks of “psychonoxious practitioners” while increasing the number of helpful counselors (p. 301). On the basis of a separate research review, Bergin (1971) concluded that the previous four decades of the practice of psychotherapy has had an effect that is modestly positive. However, Bergin (1971) pointed out that “the average group data on which this conclusion is based obscure the multiplicity of processes occurring in therapy, some of which are now known to be either unproductive or actually harmful” (p. 263). Lambert et al. (1986) also found evidence to support the position that psychotherapy is for better or for worse and that some therapists are detrimental enough to clients to affect outcome data. These findings were consistent with those in Period 1 identifying certain therapist behaviors as thwarting therapeutic outcome. It is interesting that research on this rather dire finding, which suggests that therapists low on the conditions postulated by Rogers were detrimental to their clients, virtually disappeared with the advent of the thrust for “specificity” studies in the 1980s and 1990s.

4. *The core conditions are necessary but not sufficient for therapeutic personality change* (late 1970s and early 1980s). Reviews during the middle 1970s through the 1980s included some that offered equivocal conclusions for Rogers's hypothesis of the necessary and sufficient conditions. Change in the direction of research began in the middle 1970s paralleling these equivocal reviews. The conclusions of the equivocal reviews that were supported with some data were that (a) “more complex relationships exist among therapists, patients, and techniques” (Parloff et al., 1978, p. 273) and that (b) the conditions need to undergo more thorough investigation (Bozarth, 1983; Mitchell, Bozarth, & Krauft, 1977; Watson, 1984). Opinions predicated on other theoretical formulations rather than on data included the view that the core conditions were nonspecific and similar to placebo effect (Luborsky, Singer, & Luborsky, 1975; Shapiro, 1971) and that “the conditions are neither necessary nor sufficient although it seems clear that such conditions are facilitative” (Gelso & Carter, 1985, p. 220). Issues that need resolution were cited by Beutler, Crago, and Arismendi (1986) as the need to find “an acceptance of an optimal level of

therapeutic skill, common methods of measurement, and the creation and control of levels of the facilitative skills” (p. 276). For the most part, the equivocal reviews founded on examination of the research data pointed to the need for more extensive examination of the complex phenomena. They called for more rigorous methodological designs to confirm the quasi-designs of most of the studies. Among the critical observations, Mitchell et al. (1977) discovered that many of the studies reporting the levels of the conditions were comparisons between therapists “who are non-facilitative and those who are barely facilitative” (p. 498) as operationally defined by the scales. This phenomenon was previously observed in two national studies sponsored by the National Institute of Mental Health and Rehabilitation Services Administration: The Arkansas Psychotherapy Study (Mitchell et al., 1977, pp. 484–488) and a comparably designed study of rehabilitation counselors (Bozarth & Rubin, 1975). One interpretation of this finding is that the attitudinal conditions are quite robust; that is, that in most instances the levels of the conditions can be minimally facilitative and still make a difference in client outcome. Patterson (1984) analyzed the reviews of therapist variables in relation to outcome. He pointed to the specific bias of the reviews and concluded that the effects of the necessary and sufficient conditions are grossly underestimated.

Stubbs and Bozarth (1994) did not find one direct study that supported the assertion that the conditions are not sufficient. Nevertheless, this presumption seemed to affect (or perhaps served as a rationalization for) the direction of research. The research shifted from examining the attitudinal conditions and common variable factors to investigating specificity. This shift was clearly not predicated on previous research results.

5. *There are specific techniques that are uniquely effective in treating particular disorders* (late 1989s and 1990s). The search for the effectiveness of techniques and for specificity virtually paralleled a decrease in published studies on the Rogerian hypothesis of the necessary and sufficient conditions. On the face of it, studies in CCT and the conditions therapy theory were no longer viable inquiries in the United States.

After the middle 1980s, the Rogerian hypothesis was investigated by only a dozen outcome studies that emphasized therapists' empathy (Sexton & Whiston, 1994). These studies were all positive. They included a study of therapist variables that found that emotional adjustment, relationship attitudes, and

empathy were most predictive of effective therapists (Lafferty, Beutler, & Crago, 1989). Positive therapy outcome in several studies was linked to such constructs as understanding and involvement (Gaston & Marmar, 1994), warmth and friendliness (Gomes-Schwartz, 1978), and similar constructs (Bachelor, 1991; Gaston 1991; Windholtz & Silbershatz, 1988). Empathy was strongly related to improvement for clients with depression who were being treated by CBT (Burns & Nolen-Hoeksema, 1992). Despite the many positive findings, the equivocal reviews of the conditions therapy research influenced rationale for research toward specificity of treatment. The focus on specificity research replaced inquiry on the common factors.

In summary, this period can be characterized as a major shift of the research from CCT to research on Rogers's (1957) integration or conditions therapy hypothesis. The studies examined the attitudinal conditions experienced by the therapists toward their clients regardless of the therapists' theoretical orientations. The studies reflect the pervasive effect of Rogers's hypothesis of the necessary and sufficient conditions for therapeutic personality change on psychotherapy outcome research. In addition, the studies overwhelmingly support the relationship of these conditions to successful psychotherapy outcome. This holds true even though many of the studies involve therapists who are minimally high on the conditions.

This period is also characterized by an extreme shift in the direction of research. The shift from examination of common factors to examination of specific treatment for particular dysfunction is unfounded by the research evidence.

THE FOURTH PERIOD: COMMON FACTORS REVISITED (1987–1999)

The investigations of specificity research have ironically returned full cycle to Rogers's basic premises. Research on specific variables include numerous studies in the 1990s that cite person-centered therapies as effective with a range of client problems. The studies include therapies that hold the conditions as central in the treatment process and are derivatives of the client-centered tradition (e.g., experiential therapy and process-experiential therapy). The studies include investigations of alcoholism, anxiety disorders, and personality disorders (see Bohart, 1994; Swildens, 1990). The effectiveness of person-centered psychotherapy has been reported in studies that include treatments of anxiety, psychosomatic problems, agoraphobia,

interpersonal difficulties, depression, cancer, and schizophrenia (Borkovek et al., 1987; Elliott, 1997; Grawe, Caspar, & Ambuhl, 1990; Meyer, 1981; Prouty, 1990; Teusch, & Boehme, 1991). In studies of person-centered therapy with specific problems or particular groups, person-centered therapies proved to be as viable as the more goal-oriented therapies. Furthermore, CCT compared favorably over the years in time-limited treatment (Lambert & Anderson, 1996; Shlien et al., 1962).

Stubbs and Bozarth (1994) concluded: "Over four decades, the major thread in psychotherapy efficacy research is the presence of the therapist attitudes hypothesized by Rogers" (p. 120). Duncan and Moynihan (1994) independently buttressed this assessment of Rogers's (1957) hypothesis in a report titled, "Applying Outcome Research: Intentional Utilization of the Client's Frame of Reference." Using outcome research to develop a treatment model, they concluded that the major operational variable is the utility of intentionally using the client's frame of reference. Their model parallels CCT in method and intention (Bozarth, 1998, pp. 168–169). Duncan and Moynihan's article parallels an explosion of psychological literature that identifies the common factors of client–therapist relationship and client resources as the basis for most psychological improvement (Asay & Lambert, 1999; Duncan, Hubble, & Miller, 1997; Hubble et al., 1999; Lambert, 1992; Miller, Duncan, & Hubble, 1997).

The clear message of five decades of research identifies the relationship of the client and therapist in combination with the resources of the client (extratherapeutic variables) that respectively account for 30% and 40% of the variance in successful psychotherapy. Techniques account for 15% of the success variance, comparable with a 15% success rate related to placebo effect.

In summary, the reviews of outcome research of this period reveal that (a) effective psychotherapy is predicated on the relationship of the therapist and client in combination with the inner and external resources of the client (common factors; Hubble et al., 1999); (b) type of therapy and technique add little to the effect of the relationship and client resources if not accompanied by common factors (Hubble et al., 1999); and (c) relationship variables that are most often related to effectiveness are the conditions of empathy, genuineness, and unconditional positive regard (Bozarth, 1998; Patterson, 1984; Stubbs & Bozarth, 1994).

IMPLICATIONS OF RESEARCH FOR PRACTICE

The variables of the client–therapist relationship and the resources of the client identified by research in psychotherapy outcome have been and

are the express focus of CCT. The foundation block of the person-centered approach is the self-authority and self-determination of the client. It is the client who directs and orchestrates the process and progress. The “instructions” of CCT theory are that the therapist must be genuine and experience empathic understanding of the client’s frame of reference and experience unconditional positive regard toward the client. If the client is in relationship with the therapist, is incongruent at the time, and perceives these experiences in a congruent therapist, then the client will discover his or her inner and outer resources. The dedication of the therapist to empathically experience the client’s frame of reference creates an absolute loyalty to the client’s direction, pace, and manner. There are many examples of Rogers’s response patterns representing his communication of empathy and regard to his clients (Bozarth, 1984, 1990, 1997; Brodley, 1977, 1991, 1994, 1996, 1999; Brodley & Brody, 1990; Brody, 1991; Farber, Brink, & Raskin, 1996; Merry, 1996; Rogers, 1951, 1975; Teich, 1992). However, it is the therapists’ attitudes rather than any particular response system that creates the therapeutic climate for growth (Bozarth, 1998; Bozarth & Brodley, 1986; Rogers, 1957, 1975). Limited space prohibits discussion concerning response systems in this chapter. The reader is referred to Brodley’s writings for in-depth reference to this topic. The following examples offer two different types of interactions in which the therapists’ intentions are to experience the client’s frame of reference and to experience unconditional positive regard toward the client.

The Case of Sylvia

The following is an example of a client–therapist relationship and the development of the client’s utilization of her own resources. Carl Rogers demonstrates accepting and empathic attitudes in the therapeutic relationship as well as using the more predominant empathic understanding response pattern of many client-centered therapists. This example is offered to demonstrate typical empathic understanding responses and also as an example of some struggle by Rogers to maintain his empathic stance. He deviates slightly from empathic understanding responses that are often characteristic of responses by classical client-centered therapists.

This transcript is presented from a full text that is presented in another publication (Farber et al., 1996, pp. 261–274) that is followed by two commentaries.¹ Although the demonstration is with an individual dealing

¹From *The Psychotherapy of Carl Rogers: Cases and Commentary*, by B. A. Farber, D. C. Brink, and P. M. Raskin, 1996, pp. 261–274. Copyright 1996 by Guilford Press. Reprinted with permission.

with moderate problems, Rogers's responses and relationship with the individual is similar to his work with "more difficult" clients (see Mr. Brown in the Farber et al. casebook). From their unique perspectives, both commentaries in the casebook (by Maureen O'Hara and David Cain) of Sylvia's session view some of Rogers's responses as insertions of his own bias and as having missed the mark on occasion. Such speculations, whether accurate or not, are well taken in that we are reminded of the true healing source, the client. When the therapist trusts the client for direction and trusts in the client's individual process, the client is able to correct or ignore the therapist's imperfections.

This is the fifth interview of Carl Rogers (C.R.) with Sylvia, which was recorded in 1976 (Farber et al., 1996, pp. 261–274). The fourth interview was held on the previous day. There were three interviews a year earlier. Part of the session is shown as it was recorded, with comments offered by Sylvia and Rogers after reviewing the transcript. Comments are in brackets.

C.R.: Well, where would you like to start this morning?

Sylvia: Well, uh, I want to tell you about something that I've been thinking about and that it's a, a sharing more than telling you a problem.

C.R.: M-hm, m-hm.

[C.R.: So often clients and counselors get the feeling that the relationship is one which must be filled only with problems. Sylvia gives a little indication of that, this is just a sharing, it's not a problem.]

Sylvia: And that is, I just recently noticed in myself that I've been learning. (C.R.: M-hm.) And that's a big deal. Uh, I hear people say that all the time, "Oh, I've learned so much, I learned this, and I learned that, and that was such a learning experience." And I, all these years that I've been growing up, I haven't felt any learning, and I feel, "Well, what did you learn and how did you know that you learned it?" And it was a mystery to me. (C.R.: Uh-huh.) And just the last few weeks, or, actually I've been realizing the last year, mainly, is that I learned some things and I know I've learned them, and I know that, OK, that I'm at this point and with a certain situation or idea, and that 6 months ago or 3 months ago it was different. (C.R.: Uh-huh.) And so I'm feeling my learning, and that's really exciting.

C.R.: It's the awareness of it that's new. (Sylvia: Uh-huh.) That you're beginning to realize, "Hey, I am different in this respect, I've learned something."

[C.R.: A relationship should be one in which good feelings have just as much place as bad feelings, and here she is bringing out some very positive feelings about herself, which is a healthy and valid part of a counseling relationship. It's always exciting to me to hear a client telling of positive steps which he or she has been taking, and here Sylvia sounds confident because she is doing something that she has decided

to do in her own way, not necessarily following all the books, but doing what she feels and experiences is right.]

Sylvia: I've changed. (C.R.: Uh-huh.) And I can see the difference and feel the difference. (C.R.: Uh-huh.) Yeah.

C.R.: What are some of those differences?

Sylvia: Well (small laugh), um, I, I've made a decision to be more strict with my children and to, uh, to listen to them but decide that I'm their mother and I know many things they don't, and that I will make many more decisions than I've made in the past. And uh—

C.R.: M-hm, m-hm. Sounds as though you feel a bit stronger that way.

Sylvia: Yes. And, and I've been trying it. (C.R.: Uh, m-hm.) Trying being the more strict person and it's working beautifully. (C.R.: Uh-huh.) Uh, they at first they, you know have their little resistance or whatever it is, but then we go on with the program, which is my program more, and I feel a lot better about that as being, uh, uh, helping children to adjust to the world.

C.R.: Sounds, sounds as though you feel more like a grown-up mother.

Sylvia: M-hm. Capable. (C.R.: M-hm.) Of making appropriate decisions. (C.R.: M-hm.) For them. And another area is sex. And, uh, and I, I've done a lot of things in the past year, in the past mainly year that I haven't done before. That is, I've had intercourse with a few different men and put myself in situations where before I was absolutely unwilling to do because of my fears and, and I've learned some things about myself, like I know a lot more right now today about what kind of sexual relationship, what kind of intimate relationships that I want to have with men and that feels good. (C.R.: M-hm.) Beca—, and, um, and it only came through, uh, risking. I mean there was no, it only came through trying things out, there was no amount—(C.R.: Uh-huh, Uh-huh.) There was no amount of therapy or reading or thinking or talking that helped me to learn those things, but it was feeling strong enough within myself that I could take chances.

C.R.: So risking has been the road to learning in the sexual area.

Sylvia: Yes. Uh-huh. (C.R.: M-hm.) And it is with my children, and it is with relating to people in many ways, not just sexually. (C.R.: M-hm.) Other ways too.

C.R.: M-hm.

[C.R.: Sylvia is showing a lot of risking behavior. She is risking a good deal to talk about things like this on film. But what's more important is that she has come to the point in her own life where she realizes that her own experience is the best guide for her. Not books, not therapy, not anything outside of herself. It is her own experience from which she can learn, and here she is learning in a very sensitive and personal area and is willing to share that with us.]

Sylvia: Reaching out to people and approaching strangers and uh—

C.R.: Taking all kinds of risks that you hadn't before.

Sylvia: Some. More, which, I mean I, I don't know about all kinds.

C.R.: Yeah.

Sylvia: Quite a few, and it's been exciting and hard.

C.R.: And I guess that leads to a, um, a deeper kind of learning, at any rate a learning that you feel more sure of. I get, I get a sense of assurance in what you're talking about. Assurance in you.

[C.R.: One thing that has been true with Sylvia is in every interview we have had is that she thinks carefully about what she says, she thinks carefully about what I say, and when what I say is not correct, doesn't match her experience, she's quite willing to correct me. She is very precise in both describing her own feelings and also in making sure that my response to them is accurate.]

Sylvia: Well, yes. Yes and no. And I, I feel more im—, like I was saying before, I feel more mature and more, and I'm more aware of my immaturity. (C.R.: M-hm.) They're both, uh, a part of each other. (C.R.: M-hm.) And uh, does that make—does that, I guess I'm thinking that it just sounds crazy.

C.R.: No, I don't—

Sylvia: To say that I feel more mature because I know I'm how, I know more about how immature I am.

C.R.: Uh-huh. No, that makes a lot of sense to me.

[Sylvia: I was surprised that what I said made sense to him. I think that I thought that it made sense to me, but that doesn't necessarily mean it would make sense to other people. I mean, it made sense in my own system. It felt good that he could understand me, and he knew I valued that it made sense to him too.]

[C.R.: It's important to Sylvia to make sure she is accurately understood. Can anyone understand how she can be more mature by being aware of her immaturity? Well, to me, that is quite understandable, but it's clear that she wants to make certain that my understanding extends to that degree.]

Sylvia: It does.

C.R.: Uh-huh. Because you're, you're, uh, more aware of all aspects of yourself, and it sounds more acceptant of them too. "Yes, I'm mature in certain ways and here are some ways I know I'm immature."

Sylvia: M-hm. And I didn't know that before, or I, I knew I felt uncomfortable that I didn't understand it. (C.R.: M-hm.) But that is related to something I've been thinking about, I think, about being here with you and, uh, and telling myself two things. One is, "Oh, you're just a," I'm just a dependent personality, you know, Carl Rogers or blah-blah-blah-blah, don't I don't run my own life. I go for help a lot. And then I tell myself I'm always being so strong and so together and having everything so worked out in my head that I don't allow myself to be, to be helpless in a situation where it might be good for me. Like right here now, with you, I would like to be more helpless,

which to me means open, I think. (C.R.: M-hm, m-hm.) To what to us, and, uh, and I see myself being, uh, together and not being helpless. [Sylvia: I think at that point I was feeling concern that I was just gonna go to another session of being, oh, in control of things and rattling on and on. I probably made a conscious decision that I have to do something to, to break that and, uh, which was talk about it, talk about my fear. My fear was a concern that I wouldn't learn anything.]

C.R.: M-hm. Sounds as though you, you voice that as a conflict, but it sounds as though really you're more on the, on the side of the second aspect that, uh, uh, to be open and, and in that sense helpless and vulnerable, I guess might be a possible term too, uh, is something you, you really believe that is what you are, rather than that you're a totally dependent person and really helpless and have to, have to run for help. I sort of get the feeling you like this aspect of you that is able to be with me in a way that is, uh, more open, more vulnerable perhaps.

Sylvia: Well, I like it, and I also scold myself for being dependent, so there is—

C.R.: There are two sides, uh-huh.

Sylvia: There is something missing in the middle to connect, and I, it seems like you might have been talking about that and I still didn't hear it.

C.R.: M-hm. So really to get it more accurately, you scold yourself for, for being dependent, for, for wanting to be here, for example, with me, and yet at the same time you, you feel, uh, well, that's good, I, I really like that, but where's the, where's the integration of those two, uh, points of view.

Sylvia: M-hm.

[Sylvia: That seemed to me like a very excellent, uh, not paraphrase, but when he, you know, tells me back what he thinks I meant. It, um, solidified what I expressed in the previous comment about that there was something missing. It made more sense to me.] That's right. (Small laugh) May I hold your hands again?

C.R.: Sure. M-hm.

Sylvia: We feel an old feeling.

C.R.: OK.

[Sylvia: When we did the filming in A _____, we held each other's hands the whole time, and I imagine it occurred to me that it might be good to do that again. I feel good. At that time, I, I wanted to get away from being in my head so completely the whole time, experiencing.]

[C.R.: I felt very comfortable during this holding of hands. Uh, I'm reminded of a friend of mine who said that he did eye therapy and, uh, in a sense that is what this was. Our eyes were very much in contact, and, uh, I think as much was going on at a nonverbal way as in a verbal way. It was a close relationship, and we both experienced it that way.]

Sylvia: (Clears throat) I would like to be less, uh, less strong right now. I would like to give myself the gift of not having to be sensible and reasonable and—(C.R.: M-hm, m-hm.) Also the protection, protect, protect myself.

C.R.: M-hm, m-hm, m-hm. Really would be giving yourself a gift if you could just kind of let go and not, uh, not be so competent and able— [C.R. It seems clear that the reason she wants to hold my hands is that she wants to experience something that is very frightening to her, namely to drop her competent, reasonable, strong self and let herself be some of the weakness and vulnerability that she is.]

Sylvia: M-hm, m-hm. And I think that it helps to touch you, to, to, to let go of the should, of my shoulds. (Small laugh)

C.R.: M-hm, m-hm. And you feel some contact and maybe you can say, “Well, maybe I don’t have to be so strong, so—” (Sylvia: M-hm.) “Maybe I can just let go more.”

Sylvia: Yes. (Small laugh) (20-second pause) I want to get away from all, um, my rationalizing right now this minute, and I don’t know how to do that except to shut up. (C.R.: M-hm, m-hm.) And, so it is not like I have so much a desire to sit and not talk and look in your eyes as I have a desire to not be the way I am all the time. (C.R.: M-hm.) And I don’t know yet what else to do.

C.R.: You have to be kind of silent, to let go of that rational and rationalizing part of you.

[C.R. In the interviews that we held a year ago, the silences were very long and Sylvia found a great deal of security and, uh, seemed to profit a great deal from holding my hands during the interview, and here she returns to the pattern of a year ago. It’s another indication of the fact that these interviews with her perhaps rest more solidly on just the fact of the relationship than they do even on the content of what she’s saying and talking about.]

Sylvia: M-hm. (20-second pause) It feels easier to focus on, uh, in this position that I’m in now with you, I feel more focused, yeah.

C.R.: M-hm. Are there any things that sort of come bubbling up?

Sylvia: Yeah, I know it is something I want to talk about.

C.R.: OK. M-hm. (10-second pause) but it’s not easy, huh.

Sylvia: No, it’s not easy, and I’m enjoying the richness of feeling— (C.R.: M-hm.) Your hands this way and letting go of some more of, of the camera business and the—(C.R.: M-hm, m-hm.) And, uh, and the fear about bringing up something that (laughs) (clears throat) and knowing that in about 15 minutes, it’ll all seem, um, I don’t know, not quite as serious.

[Sylvia: It just had to take its own time for me to get where I could feel like I could say the words that I needed to say. It was almost like waiting and just like, uh, you know, what else is new while I’m waiting? For something that took a natural process that it had to take.]

C.R.: M-hm.

[C.R.: If anyone has a doubt about the value of silences, it should be removed by this interchange. Sylvia is saying, "I'm doing more work when I'm silent than I am when I'm talking."]

[Sylvia: His specific comments or the content of his comments is not necessarily helpful as opposed to not helpful. But what it does do that is valuable is that it gives me something to bounce against. It's a stimulation to better focus myself.]

Sylvia: There's something I've been wanting to talk over with you.

C.R.: OK.

Sylvia continues with discussion of her attraction to Black men and to the Black culture and the implications that she perceives this to create for her. Rogers's interaction and response repertoire changes little from that depicted above even though this appeared to be a more difficult area for her to discuss.

This session is an illustration of the way in which CCT as a therapy (if not *the* therapy) emphasizes the client–therapist relationship and dedication to the client's resources. In addition, the session emphasizes therapy as more than a focus on problems; it can call on the therapist's willingness (in this case, Rogers), on the client's request, to share himself, and on the therapist's willingness to correct his understandings. Most importantly, the therapist's responses and acceptance facilitate the client's internal and external resources. It is the client who orchestrates her own direction and process.

The Case of Gerald

The next example is that of CCT with a client who was in a state mental hospital (Bozarth, 1999) in the late 1950s. The vignette demonstrates the therapist's commitment to the client's frame of reference in a way that did not necessarily involve the usual empathic understanding response repertoire. The sessions involved long silences, brief discussions about a job search, and the therapist's periodic fear of the client. Gerald was a 21-year-old who was diagnosed with schizophrenia when admitted to the hospital 2 years before his contact with the therapist. The therapist was a psychiatric rehabilitation counselor who conducted therapy and had access to resources to assist clients with vocational training and job placement. Gerald (G) was referred by his doctor and by his work supervisor. Gerald worked as a garbage collector in the hospital but was periodically transferred to a locked ward because of violent behavior toward staff and other patients. The following is part of the therapist's (T) report:

We sat mostly in silence over a half dozen or so sessions. We then continued one to three times a week for over a year. Silence continued to be a large part of the sessions. The sessions ranged from twenty minutes to an hour. Although an hour was scheduled for him, he usually left before thirty minutes. I would say things to him or ask questions

every once in awhile. He would briefly respond. I could often “feel” anger exuding from him. I would tell him occasionally that I was sometimes afraid of him. He kept returning. Here is an example of one of our interchanges that is reconstructed from written notes:

The therapist talked with Gerald’s doctor. Surprisingly, the doctor said Gerald could have an off grounds pass if the therapist agreed and monitored Gerald during that time. The following week, Gerald was interviewed at the employment office. I waited for him in the car. He felt that the interview went well. During the next session the following week, Gerald had an announcement:

G: Well, I think I’ll get out of here pretty soon.

T: Out of the hospital?

G: Yeah, doctor said when I get a job, I can get out.

(Pause of five or so minutes)

T: So I guess it is up to me to get you out of here?

[After a few minutes pause, both of us laughed with a mutual understanding. It was this experience of laughter with Gerald that both of us acknowledged his need to depend upon me at certain times and my willingness to accommodate him. (Here, the relationship was enhanced with a nonverbal experience between them.)]

G: I think I’ll work a little while yet here; they will pay me a little now to work on the truck. They like my work.

The sessions carried on for awhile this way. During the last session, Gerald talked about his family and that he might go back with them. Shortly after that, he was suddenly discharged. He had a job and was going to live with his family. He stopped by to see me but I was not there.

Three years later, the therapist received a letter from Gerald that thanked the therapist for his help and for “believing in me.” He did not give details but reported doing well. This was not the end of information about him though. More than 15 years later, the therapist was chairing a university graduate program in another state. He was cleaning up old student files that had gathered years before his arrival and came across Gerald’s name. It had to be Gerald because of his previous residence and other factors as well as his last name. He had been in military service, honorably discharged, and received his graduate degree in a helping profession. It is still difficult to believe that this coincidence occurred 15 years after therapy.

There were no great empathic understanding responses in the dialogue, no noticeable “moments of movement,” but Gerald had a relationship with someone who supported him and went with Gerald’s feelings, expressions, and internal frame of reference on a moment-to-moment basis, sometimes when logic might dictate otherwise. Gerald’s resources, both internal and external, were predominant factors. His motivation to get out of the hospital and his eventual perception of his family as supportive of him were variables that supported his own theory of change. Many potent factors must have

come into his life over the years. Nevertheless, Gerald viewed the relationship as helpful to him over 3 years later. His motivation to get out of the hospital and his desire to work, along with a new type of family support that was not available to him earlier in his hospital stay, were later variables that supported his own “theory of change” (Hubble et al., 1999).

CONCLUSION: EVOLUTION OF A REVOLUTION

This chapter reviewed research in CCT. Our focus was on quantitative research with few references to the wealth of qualitative studies that first defined the examination of psychotherapy sessions. Our discoveries went beyond our focus on the results of quantitative studies. These discoveries were the following:

1. Rogers and his colleagues revolutionized the field of psychotherapy with their seminal studies of the verbal interchange in psychotherapy sessions and with their use of qualitative and quantitative research methods.
2. Rogers and his colleagues introduced scientific hypothesis testing research to the field of psychotherapy.
3. Several periods of client-centered research are identified: (a) nondirective therapy (1940–1951), (b) the client-centered relationship (1951–1957), (c) conditions of therapy (1957–1987), and (d) common factors revisited (1987–1999). The first period, nondirective therapy, was characterized by the idea that rapport and acceptance facilitated the client’s own acceptance of self. The client rather than the therapist was the person to be in charge. The research identified nondirective therapy as being related to increased understanding, more positive feelings, greater self-exploration, improved self-concepts, and improved maturity of clients. Nondirective therapy was found to be as effective as other therapies.

The second period, the client-centered relationship, was characterized by a shift from clarification of feelings to focus on the client’s frame of reference. Research ranging from self-concept studies to effectiveness variables confirmed many of Rogers’s hypotheses.

The third period, conditions of therapy, revealed a radical shift of research from client-centered therapy to conditions therapy. Conditions therapy referred to the necessary and sufficient condition and was hypothesized to be the foundation of all successful therapy. The results overwhelmingly

support the relationship of the attitudinal conditions to successful psychotherapy outcome.

The fourth period, common conditions revisited, offered strong evidence that the factors most associated with successful psychotherapy are the relationship of the client and therapist and the resources of the client.

4. There was little research on CCT after Rogers's (1957) hypothesis of the necessary and sufficient conditions of therapeutic personality change (the attitudinal conditions), and after the Wisconsin investigation of psychotherapy with patients hospitalized with psychoses (Rogers et al., 1967). The research shifted to studies of the attitudinal conditions of therapists regardless of theoretical orientations.
5. The research on the attitudinal conditions started shortly before the third period, and research on these attitudes dominated psychotherapy outcome studies during 1950 through 1970.
6. There is substantial research supporting Rogers's attitudinal conditions. This is particularly true from the middle 1950s through the 1970s.
7. Rigorously designed studies in Germany (see R. Tausch & Tausch, 1990) confirm the effectiveness of the attitudinal conditions and of CCT.
8. The confirmation of the attitudinal conditions over two decades was dismissed with the rationale that the conditions had been found to be "necessary but not sufficient." This assumption was predicated on less than a half dozen reviews that primarily called for increased rigor of research designs. There was, in fact, no research evidence to support the contention of the conditions being necessary but not sufficient.
9. Psychotherapy outcome was dominated with specificity research during the 1990s. This research effort ignored the findings of the previous 3 decades of research.
10. Specificity studies that included secondary common factors (e.g., empathy) identified common factors as being related most often to positive outcome. This fact, and the results of the research in the previous period, lay a strong foundation for support of the basic foundation of CCT, namely, the attitudinal conditions.
11. Research reviews of psychotherapy outcome in the late 1990s (see Hubble et al., 1999) found that successful outcome was predominantly related to the variables of the client-therapist relationship and to the extratherapeutic variables of the cli-

ent. The extratherapeutic variables include client resources and client happenstance.

In short, psychotherapy outcome research supports the major tenets of CCT. The therapeutic relationship and the client's resources are the crux of successful therapy and the foundation of CCT. It is clear that Rogers's specific hypothesis of the necessary and sufficient conditions and his conditions therapy theory have received much more empirical support than some of the equivocal reviews of the middle 1970s imply. Research has supported the theory that a congruent therapist's experience of empathic understanding of the client's frame of reference and experience of unconditional positive regard are related to positive outcome. The potency of these conditions becomes even more apparent with realization that most studies compare therapists who are rated as minimally high with therapists who are rated low on the conditions. Few studies in the United States since the early 1960s have included client-centered therapists who focus on Rogers's postulates of the necessary and sufficient conditions as central to therapeutic change. Some studies in Europe, especially Germany, have included client-centered therapists.

It is our contention that the empathic stance of the therapist fosters the relationship. In addition, empathy helps clarify, identify, and promote extratherapeutic variables. Empathy also promotes the relationship in a way that is more apt to keep the attention on the "client's theory of change" (Hubble et al., 1999) rather than on the therapist's objectives. This point is accentuated with the model of the intentional utilization of the client's frame of reference proposed by Duncan and Moynihan (1994), a model based on psychotherapy outcome research. Their model is essentially a reiteration of Rogers's theory. We believe that Rogerian empathy, which is inseparable from unconditional positive regard (Bozarth, 1997), is the most viable "utilization" of the client's frame of reference.

What are the implications of the research for the training of psychotherapists? The most important aspect of training is to develop the attitudes of the therapist as a dedicated servant to the client's perception of the world. First and foremost, the research supports the therapist who attends to the therapeutic relationship and to the client's own resources. It is the client who discovers personal power from relationship with the therapist and from his or her own inner resources. The most viable training goal in CCT is that of enabling therapists to develop their own unconditional positive self-regard to experience unconditional positive regard and emphatic understanding toward their clients. A most powerful learning about the therapeutic relationship can come from the opportunity for the therapist to experience the remarkable potency of going with the client's internal frame of reference without interruption, intervention, supplementation, and expertise.

Decades of research on CCT and, especially, on the necessary and sufficient conditions of therapeutic personality change suggest that the real potency of successful therapy is the client, and the therapist's attention to the individual client's frame of reference fosters the client's utilization of inner and outer resources. CCT offers a viable model for this endeavor.

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