Client-Centered Therapy: Its Place in Contemporary Times

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Abstract

This paper considers the philosophical, clinical, and scientific bases of client-centered therapy (CCT). Following a description of the fundamental tenets of CCT, issues concerning its psychotherapeutic effectiveness will be considered. First, the relationship between the core features of CCT and therapeutic outcome will be examined. This will be followed by an examination of the research addressing the effectiveness of CCT. Finally, two issues regarding the contemporary role of CCT are discussed. It is suggested that it may be more appropriate to consider CCT as a common ingredient to effective forms of therapy, or as a precursor to effective therapies. This latter point is examined within the context of process-experiential therapy.
Client-centered Therapy: Its Place in Contemporary Times

In the 1940’s, Carl Rogers made the psychological world take notice. His seemingly radical views, as reflected in his criticisms of the dominant psychological theories (i.e., psychodynamic and behavioral) and his proposed approach to therapy (that was informed by a fundamentally different philosophy of human nature), challenged and, ultimately, changed both the conceptualization and practice of psychotherapy (Bozarth, Zimring & Tausch, 2002; Cain, 2002; Raskin, 1996). Rogers continued to be very influential and have a strong presence for several decades. More recently, however, interest has waned, especially with regards to client-centered therapy (CCT), as conceptualized by Rogers (Hill & Nakayama, 2000; Raskin, 1996). It has even been suggested that the field has progressed beyond Rogers’ conceptualization of therapy (Norcross, 2001, as cited by Cornelius-White, 2002).

This position has been rejected by several humanistic psychologists (and others) (Bozarth, et al., 2002; Cain, 2002; Cornelius-White, 2002; Walker, 2001), arguing that Rogers’ influence continues to be notable in at least two regards. First, while it is acknowledged that the practice of humanistic therapies, and in particular CCT, has declined, it is argued that they are still practiced widely, especially outside of North America (Bozarth, et al., 2002; Hill & Nakayama, 2000; Raskin, 1996). Moreover, interest within North America may have been rekindled with the emergence of more integrative, process-directive humanistic therapies (Bozarth, et al., 2002; Cornelius-White, 2002; see also Walker, 2001). Secondly, it has been suggested that the essence of CCT is a critical aspect of all therapeutic styles (Cornelius-White, 2002; Walker, 2001) and, furthermore, may conceptually be at the heart of the “common factor” of psychotherapy (Bozarth, et al., 2002).

The present paper examines the theoretical, clinical, and scientific bases of CCT. In addition, its role in the context of contemporary views of psychotherapy, especially with respect to the two arguments outlined above, is considered. With respect to the relationship between CCT and contemporary humanistic therapies, this paper will focus exclusively on process-experiential therapy (PET; Elliott & Greenberg, 2002; Greenberg, Rice & Elliott, 1993), an approach that shares key elements with CCT but is also informed by aspects of existential, Gestalt, and experiential humanistic therapies (Cain, 2002; Elliott & Greenberg, 2002; Greenberg, et al., 1993).

**Theoretical Underpinnings of Client-Centered Therapy**

The belief that there is an inherent tendency for individuals to develop to their fullest potential is fundamental to client-centered (Rogers, 1951, 1980) and, as well, process-experiential approaches to therapy (Elliott
& Greenberg, 2002; Greenberg, et al., 1993). Drawing upon philosophical, biological, and psychological theories, Rogers described the “actualizing tendency” as a directional process (Rogers, 1951, 1980; see also Bozarth & Brodley, 1991; and Rogers, 1980 for a detailed discussion of these theories). While there are no set or predetermined goals, humans are considered to be essentially rational and responsible, and as such will move naturally towards autonomy, and an increased ability to self-regulate (Bozarth & Brodley, 1991; Rogers, 1980). It is acknowledged, however, that the actualizing tendency is sensitive to environmental conditions. That is, the environment (especially as reflected by interpersonal relationships) can either thwart and hinder, or support and facilitate the actualizing tendency. For example, when the acceptance or value of an individual is dependent upon extrinsic factors (i.e., conditional positive regard), a conflict between the **real self** (i.e., the actual core of experience) and the **perceived self** (i.e., the self that the individual aspires to be) is experienced (Rogers, 1951). When such a discrepancy exists, the individual may come to feel sad, dissatisfied, vulnerable, or anxious. It can lead to a sense of personal worthlessness. Moreover, it is posited that the greater the discrepancy between exhibited behaviors and held values, the greater the likelihood that the actualizing tendency will be stifled.

Importantly, Rogers (1951) also believed that so long as the individual was alive, there would be an inner push for movement towards congruence, that is, resolution of conflicts between real and perceived self. In this regard, he firmly held that the therapeutic relationship could be growth inducing, such that positive shifts in attitudes about the self would be evident following effective therapy (see also Raskin, 1948). To this end, he argued that the individual must experience non-judgmental acceptance by the therapist. This belief underlies Rogers’ subsequent conceptualization of the essential characteristics of the therapist (Rogers, 1992a,b). Before considering these qualities, it is important to consider briefly the characteristics of individuals whom Rogers’ believed could benefit from CCT and, as well, his conceptualization of the role of the therapist.

In general, CCT is considered to be appropriate for almost all individuals, assuming some dissatisfaction with their present level of functioning (Hill & Nakayama, 2000; Rogers, 1992a,b). Moreover, CCT has been used to treat a variety of clinical problems, including anxiety, psychosomatic problems, depression, interpersonal problems, and schizophrenia (Farber, Brink, & Raskin, 1996; see Bozarth, et al., 2002 for review). Rogers, however, acknowledged that there must be an opportunity for improvement through means other than a “radical alteration of circumstances” (Rogers, 1992b, p. 163). He further recognized that the individual has to be able to engage, at some level, with the therapist. In this regard, it is noteworthy that Sachse and Elliott (2002) observed that degree of client
engagement within the therapeutic relationship was positively correlated with outcome. Moreover, passive attitudes towards therapy were associated with poorer outcome.

The only acknowledged role of the client-centered therapist is that of providing an environment that facilitates the expression of the client’s actualizing tendency (see also Bozarth & Brodley, 1991; Cain, 2002). Thus, CCT is described as non-directive, with the therapeutic process purportedly determined completely by the client. However, Villas-Boas Bowen (1996) has suggested that it is impossible for the therapist to be completely non-directive (see also Merry & Brodley, 2002). That is, the therapist is constantly making decisions about what to respond to. So, while the goal is to respond to whatever is most important to the client, the response will necessarily reflect the perceptions and interpretations of the therapist, that in turn are shaped, in part, by factors specific to the therapist (e.g., personality, past history, etc.). It has been suggested that the design of CCT precludes or, at least, limits the therapeutic exploration of negative or hostile emotions (Dolliver, 1995). Certainly, there is evidence that the therapist’s response does impact what happens in the session (Farber, et al., 1996; Rennie, 2002; Sachse & Elliott, 2002). An example of these issues is provided in a demonstration session of client-centered therapy (American Psychological Association [APA], 1995a). Following an emotional description of a violent experience, the client, “Cynthia,” asks the therapist, Dr. Raskin, three times about the meaning or implications of this event. In keeping with the fundamental tenets of CCT (see below), Dr. Raskin refrained from answering these questions directly. However, in this author’s mind, he also did not respond to the intensity of the emotional tone of the client, a seemingly salient dimension of the exchange. Moreover, this transaction ended with Cynthia sighing heavily, pausing notably, and then moving on to an unrelated topic. Again, from this author’s perspective, the issue seemed unresolved and illustrated, perhaps, a missed opportunity to facilitate exploration of an issue that seemed to be pertinent to the client’s sense of self. It is also the author’s belief that Dr. Raskin, by responding in the manner that he did, clearly impacted the direction of the session, in a way that was not consonant with the client’s preferences.

Rogers’ Essential Attitudinal Qualities of Therapists

As indicated above, the primary goal of client-centered therapists is to create a facilitative environment for growth (Bozarth & Brodley, 1991; Cain, 2002). To this end, it is the attitude of the therapist, as opposed to specific techniques or skills, that is the basis of CCT (Hill & Nakayama, 2000; Rogers, 1951, 1992b). Rogers (1992a) identified three essential characteristics of the therapist. Specifically, the effective therapist must exhibit
unconditional positive regard and empathy for the client. In addition, the therapist must be genuine in his/her interactions with the client. These three characteristics are discussed, in turn, below.

**Unconditional Positive Regard.** This quality has been described as a non-possessive caring, a prizing, and a non-judgmental acceptance of the client by the therapist at all times. According to Rogers (1975), it is the most important condition within the therapeutic context (though not necessarily for other contexts). As previously indicated, the sense that an individual’s value to others is conditional can result in suppression of the actualizing tendency. The subsequent experiencing of unconditional positive regard within therapy serves to challenge and counter the effects of these earlier experiences. Specifically, it is held that acceptance by the therapist can help the individual to be open to all aspects of self, without judgment, thereby setting the stage for changes in perceptions of self and behaviour.

**Empathy.** Empathy is also considered to be a multi-faceted concept, one that includes specific attitudes and abilities. The empathic therapist has been described as non-judgmental, open, respectful, flexible and confident. Rogers (1975, p. 4) described empathy as a process that entails the therapist entering “the private perceptual world of the client” and, as well, the communication of his/her “sensings” to the client. Furthermore, the therapist who is guided by the client’s feedback, with regards to his/her perceptions, is considered to be empathic (Brink & Farber, 1996). Parenthetically, Dr. Raskin’s previously described response to Cynthia (APA, 1995a) appeared to reflect a lapse in empathic understanding. It is important to note, however, that Dr. Raskin appeared empathic at other times, as suggested by Cynthia’s positive responses to him and her willingness to explore aspects of her background from seemingly new perspectives.

Underlying abilities of empathy are thought to include awareness of and sensitivity for the client, especially with regards to that which has “not yet been spoken.” It is important to note that empathic understanding is considered to be inextricably linked to the therapist’s awareness of his/her own inner process (Vanaerschot, 1993). It is assumed that the therapist will draw upon his/her personal experiences in an attempt to gain an understanding of the client’s experiences. However, empathy requires that the therapist ultimately consider the experience separate from his/her personal context.

Empathy is believed to be an essential therapeutic condition because it fosters, within the client, a sense of being personally understood and accepted. This, in turn, is thought to lead to greater self-acceptance and, as well, increased capacity for growth (Greenberg, Elliott, Watson, & Bohart, 2001; Vanaerschot, 1993). Empathy is also
thought to be associated with enhanced insight (Rogers, 1992b). However, in contrast to the psychodynamic conceptualization of insight, the source of which is attributed to the therapist, Rogers argued that, in the context of CCT, insight is a reflection of the client’s emotional acceptance of self. Rogers also believed that empathic understanding promotes a sense of belonging, as the individual comes to feel valued and accepted as a person, in his or her own right (Greenberg, et al., 2001; Rogers, 1975).

**Genuine.** Being genuine refers to the therapist’s ability and willingness to be him/herself with the client. Two dimensions, inner vs. outer, have been identified (Lietaer, 1993). The inner dimension concerns the degree to which the therapist is aware of, and is responsive to, his/her own moment-to-moment feelings and attitudes. This dimension is sometimes referred to as the congruence or authenticity of the therapist. The outer dimension refers to the transparency of the therapist, that is the ability of the therapist to communicate his/her own perceptions, attitudes and feelings to the client.

The need for the therapist to be genuine was not formally identified as a fundamental condition of CCT until the 1950’s (Bozarth, et al., 2002; Cain, 2002; Raskin, 1996). Its specification reflected three influences: Rogers’ (and others) work with individuals with schizophrenia (see for e.g., Bozarth, 1996; and accompanying transcript in Farber, et al., 1996); the influence of existential therapists; and, as well, the development of the encounter movement (Litaer, 1993). According to Rogers (1980), the ability to be genuine was the most important condition with respect to everyday interactions but not necessarily for therapy. In contrast, some humanistic therapists believe that it is the most fundamental condition in CCT. For example, Lietaer (1993) advocates that it is the ability of the therapist to be aware of self, in relation to the client, that sets the stage, or allows for the therapist’s acceptance and empathic understanding of the client.

The specification of this condition as a critical component of CCT resulted in a substantive shift with regards to the content and style of therapists’ responses to the client. In particular, it was associated with increased, though limited, self-disclosure (Lietaer, 1993). Specifically, disclosure of the therapist’s perceptions, attitudes and feelings are appropriate to the extent that they pertain to the client, and it occurs in a manner that contributes to the facilitative environment required to promote the client’s development and acceptance of self.

It is noteworthy that the condition of genuineness can be especially difficult, relative to acceptance or empathy, for some therapists to experience or express. For example, Raskin (1978) described the challenges he has experienced, both in terms of self-awareness, and his willingness to be self-expressive within the therapeutic
relationship. It is noteworthy, that this author’s first, and general, impression of Raskin’s demonstration session (APA, 1995a) was that he was surprisingly distant and removed, even when talking about “precious moments” later in the session. It seemed as if he was consciously stiff (physically) and constrained in his interactions with the client. This impression was reinforced after viewing the interview that followed the demonstration session wherein he seemed more physically expressive and verbally fluent. While differences in self-expressivity across settings are to be expected, the difference between these two settings was striking from this author’s perspective.

**Expression of the Essential Attitudinal Qualities.** The attitude of the therapist, as opposed to specific techniques or skills, is central to CCT (Hill & Nakayama, 2000). Rogers (1951) believed that the therapist’s awareness of his/her experienced feelings and attitudes (i.e., being genuine) should guide the therapist’s responses to the client, with the constraint that the therapist’s intention is to demonstrate unconditional positive regard and empathic understanding. Accordingly, Rogers believed wholeheartedly that diversity in therapists’ styles would be the norm. To the extent that they were consonant with the fundamental tenets of CCT, they could, however, be equally effective.

Analysis of transcripts of numerous sessions conducted by Rogers, and other like-minded therapists, has nonetheless, led to the identification of various common ways of responding to the client (e.g., Brink & Farber, 1996; Wickman & Campbell, 2003, see also APA 1995a). For example, therapists may affirm their understanding by nodding, making eye contact, saying “m-hmm,” etc. Alternatively, they may reflect, or mirror, the gist of the client’s experiences back to the client. Such responses serve to clarify the client’s response or to integrate aspects of different responses. Responses of this type often entail the therapist going beyond what the client has explicitly stated and serve to articulate the unspoken (e.g., identifying client’s unstated feelings). The therapist, at times, may also suggest interpretations as a way of furthering the therapist’s understanding of the client’s world. However, the therapist is encouraged to be cautious, ensuring that interpretations flow from the moment (as opposed to being carefully considered and formulated in advance) (Villas-Boas Bowen, 1996). In addition, they should be offered tentatively, and, the therapist must be willing to accept correction from the client.

**Scientific Basis of Client-Centered Therapy**

In considering the scientific evidence, the present paper will consider two questions. First, is the triad of attitudinal qualities related to therapeutic outcome? Two lines of evidence will be considered -- research exploring the client’s perspective of the therapeutic process and, as well, more objective styles of research that has examined
the specific relationship between each quality and outcome. Second, is CCT an effective form of therapy? In addressing this question, the effectiveness of CCT will be considered over time, and, as well, relative to control conditions, process-experiential therapy (PET), and non-humanistic therapies.

Perceptions of the Client. Support for the notion that the attitudinal triad of acceptance, empathy, and genuineness influence the client’s perceptions, and acceptance, of self is provided by research that considered characteristics of therapists as a function of whether the therapist was appraised positively or negatively by their clients (Schneider, 1985, as cited by Rennie, 2002). One distinguishing characteristic was “personal involvement.” More specifically, therapists who were appraised positively were described as being genuine, accepting, and supportive (see also Laffert, Beutler, & Crago, 1989). Moreover, clients expressed the belief that it was these characteristics that helped them to become more genuine and accepting of themselves, and less defensive.

Relationship between Attitudinal Qualities and Therapeutic Outcome. A substantial body of literature regarding the relationship between the triad of attitudes and outcome has accumulated, including some recently published meta-analytic studies (e.g., Elliott, 2002; Greenberg et al., 2001). Most of the research has been conducted within the context of CCT, or humanistic therapies more generally, especially with regards to genuineness and acceptance. One notable limitation of the research is that each quality has typically been considered in isolation, as opposed to considering the joint impact of the three attitudes.

Unconditional positive regard, or acceptance, has generally been observed to be positively related to outcome, although exceptions have been noted (Sachse & Elliott, 2002). Discrepancies within the literature may reflect the complexity of the construct. That is, unconditional positive regard entails both a caring for the client and, as well, a non-judgmental acceptance of the client (Rogers, 1992a; 1995). Sachse & Elliott (2002) described it as a dynamic and constructive process. Accordingly, results may depend upon how the construct is measured and, also, at what point in therapy it is assessed.

Empathy has generally been observed to be positively correlated with outcome. For example, results of a recent meta-analysis indicated that empathic understanding accounted for approximately 10% of the variability in outcome (Greenberg, et al., 2001). It is interesting that the magnitude of the effect size is in keeping with the effect size commonly associated with relationship factors more generally (see Beutler & Harwood, 2002). It is also noteworthy that the relationship between empathy and outcome was evident across a variety of outcome measures, including problem-focused measures (e.g., indices of symptom severity) and, as well, non-specific measures of well-
being and client satisfaction (Greenberg, et al., 2001). The researchers did note, however, that the effect varied as a function of the type of empathy measure. Specifically, measures reflecting the perspective of the client were more predictive of outcome, relative to observer-rated or therapist measures. Similar results have been reported by Gurman (1997, as cited by Hill & Nakayama, 2000). The relatively small effect size associated with empathy is, perhaps, surprising or disappointing, especially given the centrality of empathy for CCT. The smaller than expected effect size may be due to a restriction of range in the degree of empathy exhibited by therapists. Given the nature of therapeutic work, it is conceivable that therapists will exhibit at least a minimal level of empathy, resulting in a restriction in the range of possible empathy scores. It has also been suggested that there is a threshold, such that additional gains won’t be evident beyond a certain level of empathy. Further research is required to evaluate these possibilities.

Evidence pertaining to the relationship between genuineness and therapeutic outcome is equivocal. A review of the literature (Sachse & Elliott, 2002) revealed that only 38% of published studies reported positive correlations. Moreover, a few studies have obtained negative correlations. At this time, it is not clear what factors serve to moderate the relationship between genuineness and outcome. Results may depend upon how genuineness was measured, especially with regards to whose perspective was considered. As observed with empathy, the client’s perspective may have better predictive power. It has also been suggested that there might be an effective “dose,” beyond which may be counter-productive. For example, it is possible that excessive displays of genuineness may be difficult for some clients to accept or tolerate, and as such interfere with the therapeutic process (Sachse & Elliott, 2002).

Taken together, it is apparent that each of the three attitudinal qualities is related to outcome. However, the bases of these relationships are not clear. The magnitude of the observed correlations and, as well, the inconsistent findings across studies (especially with regards to genuineness) suggests limitations to their roles. The variability also calls into question Rogers’ assumptions that the attitudinal triad is necessary and sufficient. In this regard, Sachse and Elliott (2002) concluded that while the evidence suggests that all three attitudinal qualities can be effective “tools,” it is too weak to warrant the conclusion that they are necessary conditions for therapeutic change. Bozarth and associates (2002) have also argued that these qualities are neither necessary nor sufficient but instead, are better construed as facilitative conditions for effective therapy. On the basis of the evidence to date, these conclusions appear warranted. However, further research concerning the contributions of acceptance, empathy, and
genuineness is needed. For example, it is not clear that Rogers’ assumption has been adequately tested. That is, Rogers argued that all three qualities were conjointly necessary. The research to date, has only considered each quality independently. As such, it is possible that assessment of their conjoint influence would yield a different pattern of results. Such an approach may further our understanding and appreciation of the idiosyncratic needs of clients (see Beutler & Harwood, 2001). That is, the optimal mix of acceptance, empathy, and genuineness may depend upon the individual client. It is also important to note that most of the research conducted to date has only considered the contributions of each attitude to outcome. Moreover, within a given study, the attitudes are only measured at one point in time. It is conceivable (if not likely) that each of these attitudes is dynamic and that they may contribute to the therapeutic process in different ways, at different points in time (see for e.g., Rennie, 2002; Watson & Greenberg, 1996). It is ironic, given Rogers (1951) emphasis on the importance of empirically substantiating the claims regarding CCT (and therapy more generally) and, as well, his emphasis on the use and value of session transcripts as a means for understanding the therapeutic process, that the contributions of the three attitudinal qualities has been considered in such a limited fashion.

The Effectiveness of Client-Centered Therapy. A substantial number of studies evaluating the effectiveness of humanistic therapies have been conducted. Unfortunately, many studies have not distinguished between client-centered and other forms of humanistic therapies (e.g., Gestalt, process experiential, etc.) (see Elliott & Greenberg, 2002). Accordingly, only limited conclusions can be drawn about the effectiveness of CCT per se. A recent, large-scale meta-analysis (i.e., 86 studies; 99 therapy conditions) that included a sufficient number of relatively pure CCT conditions allows for some more specific conclusions (Elliott, 2002).

Consistent with previous reports, Elliott (2002) obtained a large effect size, based upon pre vs. post comparisons, for humanistic therapies in general. Similar effect sizes were obtained when the humanistic therapies were compared with wait-list controls. In addition, Elliott observed that therapeutic change was maintained, for up to 11 months following termination of therapy. It is important to note, however, that effect sizes were found to vary as a function of how outcome was measured. The strongest effects were obtained when outcome was defined in relation to targeted or individualized complaints, or therapist-ratings of symptoms. While positive results were also obtained with broader or less specific measures of outcome (e.g., personality measures), the effect sizes tended to be smaller. It is also noteworthy that analyses failed to reveal differences as a function of the diverse characteristics of the clinical population (e.g., interpersonal problems, anxiety, schizophrenia, physical-based problems, etc.).
CCT has also been compared directly with other humanistic therapies. Of particular interest are studies that have compared CCT with process-experiential therapy (PET; Greenberg, et al., 1993). Watson & Greenberg (1996) reported equivalence in the effectiveness of CCT and PET, when outcome was evaluated immediately following termination of therapy. However, the improvements associated with PET were evident earlier in therapy, and were longer lasting. In a similar vein, Schneider (1985, as cited by Rennie, 2002) found that positively appraised therapists conveyed cognitive and experiential skills. In this regard, clients reported that these interventions helped them to be able to shift or change, to feel clearer, or to have an increased capacity to view and consider self (and others) from different perspectives. As indicated above, Elliott (2002) was also able to compare relatively pure approaches to CCT with more process directive humanistic therapies (e.g., process experiential therapy). Initial analyses indicated that larger effect sizes were associated with the process directive therapies. However, when researcher allegiance was statistically controlled, the different therapeutic approaches were found to be equivalent.

Elliott (2002) has also compared CCT, and humanistic therapies more generally, to other therapeutic approaches. Initial comparisons yielded equivocal findings. While effect sizes, based upon pre- vs. post- treatment comparisons, did not differ as a function of therapeutic orientation, substantial variability was noted across studies, such that some studies favored the humanistic therapies while others favored the non-humanistic therapies (Elliott, 2002). To determine whether any of the variability was due to differences amongst the non-humanistic approaches, Elliott (2002) compared cognitive-behavioral therapies (CBT) with “other” approaches (e.g., psychodynamic, psycho-educational, treatment as usual, etc.). Humanistic approaches (broadly defined) were reported to be somewhat more effective than the non-cognitive approaches. Caution should be exercised in interpreting this result, however, since the sample size was insufficient to permit division of the two groups into more homogeneous and theoretically coherent sub-groups (e.g., CCT vs. process directive; psychodynamic vs. psycho-educational). Moreover, the effect size was small (i.e., less than .5; Cohen, 1988, as cited by Kazdin, 2003). Comparisons between humanistic approaches and CBT failed to reveal significant differences. However, a different pattern emerged when type of humanistic therapy was considered. That is, CCT was found to be somewhat less effective than CBT. This result is consistent with previous findings (Grawe, Donati, & Bernauer, 1994, as cited by Elliott, 2002). In contrast, process-directive, humanistic therapy was somewhat more effective than CBT (see also Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). It is important to keep in mind that the effect size
associated with both of these comparisons was small. In addition, when researcher allegiance was statistically controlled, no significant differences between any of the therapeutic approaches were observed.

Taken together, it appears that CCT is an effective form of treatment. However, the limits of its effectiveness need to be substantiated and evaluated more fully. For example, while this therapeutic approach has been used with a variety of clinical populations (see Bozarth, et al., 2002 for review), it is important to explore further the conditions under which CCT can be considered an appropriate and/or preferred method of treatment. It is also difficult to make conclusive statements regarding the relative effectiveness of CCT, in comparison to other therapeutic approaches. While the research suggests intriguing similarities and differences, treatment protocol and researcher allegiance has frequently been confounded in the research. Moreover, the observed differences have been negated when researcher allegiance has been statistically controlled. It should be noted, however, that this pattern of minimal to no differences across therapeutic approaches is the norm, rather than the exception (Luborsky, et al., 2002).

Implications: CCT and the Common Factor Theory of Psychotherapy.

Taken together, the research of the contributing influences of the attitudinal triad to therapeutic outcome and, as well, the research pertaining to the effectiveness of CCT, it does not appear that CCT has outlived its usefulness (Cornelius-White, 2002). However, it may be more appropriate to conceptualize CCT as a more general “ingredient” of therapy, as opposed to a therapeutic approach in its own right.

Recently, it has been suggested that the essence of CCT may be common to all effective forms of psychotherapy (Hill & Nakayama, 2000). In this regard, most of the evidence to date suggests that the differential effectiveness of different therapies is minimal (Luborsky, et al., 2002; see Harwood & Beutler, 2002 for an opposing view). The commonly endorsed interpretation of these findings is that the various therapies do not differ substantially from one another with regards to their main “effective ingredients” (Luborsky, et al., 2002; Messer & Wampold, 2002). However, the nature of the “common” ingredient(s) has not been firmly established. It is possible that the essence of CCT, as reflected in the attitudinal triad or some aspect(s) of the triad (e.g., empathy), conceptually captures the oft-identified “common factor.” In this regard, it is noteworthy that therapist-client alliance is the most common view of the common factor (Messer & Wampold, 2002). While the results arising from investigations regarding CCT per se are pertinent, other lines of evidence also lend support for this suggestion. For example, Greenberg and associates (2001) reported that the relationship between empathy and outcome was not
moderated by the theoretical orientation of the therapist. In a similar vein, empathy is correlated with the effectiveness of individual therapists (Lafferty, et al., 1989; Schneider, 1985, as cited by Rennie, 2002). It is also interesting to note that the results of similar research, conducted in the context of other theoretical orientations, have been interpreted as indicating that the attitudinal triad is necessary but not sufficient for positive therapeutic outcome (Bozarth, 1993). This is in keeping with the idea that the triad is a critical ingredient of effective therapy. Finally, it is noteworthy that the components of the attitudinal triad were recognized by APA Division 29 Task Force as either being “demonstrably effective” (empathy) or “promising and probably effective” (genuineness, and positive regard) components of the therapeutic relationship (Ackerman, et al., 2001).

Taken together, these various lines of evidence are consistent with the suggestion that CCT, as characterized by the attitudinal triad, underlies the common factor. However, it is important to keep in mind that this suggestion is tentative at this time. Research designed to explicitly test the validity of this hypothesis is required.

Implications: Setting the Stage for Other Therapeutic Interventions.

A variation of the preceding notion also merits consideration. It has been suggested that CCT functions as a precursor to the effectiveness of other types of interventions (Hill and Nakayama, 2000; Rennie, 2002). While CCT is an effective intervention, it may not be the most efficient way of effecting therapeutic change. The use of additional interventions, including those that are more directive, may serve to further facilitate the process of change. While Rogers (1951, 1980) emphasized the exclusive importance of personal experience in promoting self-understanding, it may not be the case that other sources of information are necessarily detrimental to this process (Dolliver, 1975).

While this suggested role for CCT is assumed to apply to a variety of therapeutic approaches, it is easiest to explore this possibility, at least initially, by considering it within the context of humanistic therapies that, by definition, share a common view of human nature and, as well, “psychopathology.” Accordingly, the relationship between CCT and process-experiential therapy (PET), a manualized approach to therapy, will be examined (Greenberg, et al., 1993). To this end, a brief description of PET, highlighting the common and distinguishing features, will be provided first. This will be followed by consideration of research designed to evaluate the critical features of PET.

Process Experiential Therapy. PET shares with CCT the fundamental belief in the inherent tendency for individuals to develop to their fullest potential. Proponents of PET also acknowledge the importance of the
attitudinal triad, although it is not emphasized to the same degree and they also advocate for judicious displays of acceptance, empathy, or genuineness (Greenberg, et al., 2001). In addition, the underlying theory of PET acknowledges that the primary role of the therapist is to provide an environment that facilitates the expression of the client’s actualizing tendency. It is with regards to the precise role of the therapist, however, that critical differences between these two approaches become especially evident.

As previously indicated, CCT is described as being non-directive; as such, the role of the therapist is considered to be very limited with respect to what transpires within therapy (Bozarth & Brodley, 1991; Cain, 2002). In contrast, proponents of PET believe that therapists can further facilitate the process of therapeutic change by helping to direct the client’s process (Cain, 2002). To this end, they advocate for the use of more active (directive) interventions. It is in regards to the directive interventions that the influence of two other humanistic traditions -- Gestalt and experiential -- becomes notable. Thus, in addition to encouraging the client to attend to the “felt sense,” as advocated by Rogers (1951, PET emphasizes additional cognitive and affective “ways of knowing” (Cain, 2002). Thus, in addition to the common response styles associated with CCT, there are a number of experiential interventions associated with PET. Each intervention has clear criteria that serve to define its appropriate use (i.e., process markers) (Elliott & Greenberg, 1997; Goldman & Greenberg, 1997; Greenberg, et al., 1993). Five main sets of tasks and markers have been identified: two-chair dialogues - resolution of splits; empty chair dialogues - resolution of unfinished business; systematic evocative unfolding - resolution of problematic reactions; focusing - resolution of unclear felt sense; and, empathic affirmation - acknowledgement of feelings of vulnerability (Greenberg, et al., 1993). The majority of the interventions associated with PET are illustrated in a video of a demonstration session conducted by Dr. Greenberg (APA, 1995b). In general, each intervention occurred in accordance with the specified criteria. However, it appeared to this author that the session was somewhat incongruous with the published manual (Greenberg, et al., 1993). For example, it seemed that Dr. Greenberg provoked frequent shifts in the focus of the session by suggesting to the client different therapeutic interventions. While each task may have been technically appropriate, it appeared that some of the interventions were suggested before the work associated with the preceding task was completed. Thus, this author was left with the sense that the client did not have the opportunity to resolve many (if any) of his identified issues, during the course of the session. It is noteworthy that in a subsequent interview about the session, Dr. Greenberg acknowledged similar concerns (APA, 1995b) stating that the number of interventions was unusual, especially given the early stage of therapy.
Effectiveness of Process Experiential Therapy. As described previously, it has been demonstrated that PET is an effective therapy (Elliott, 2002; Greenberg & Watson, 1998; Watson, et al., 2003; Watson & Greenberg, 1996; see Elliott & Greenberg, 2002 for a recent review of the literature). Moreover, there is tentative evidence that PET may be somewhat more effective than CCT (Elliott, 2002), although the observed differences may be better accounted for by uncontrolled effects of researcher allegiance. Results of research that controlled for researcher allegiance indicated that improvements were evident earlier in PET and they were more durable, relative to CCT (Watson & Greenberg, 1996), suggesting that PET is more efficient than CCT.

Given these latter findings and the noted differences in the therapeutic approaches, it is important to ascertain if the increased efficiency is, in fact, directly attributable to the use of process-directive tasks. In this regard, there is a small but growing body of literature that suggests that the directive tasks are important to the therapeutic process (e.g., Schneider, 1985, as cited by Rennie, 2002; Watson & Greenberg, 1996). In addition, it has been posited that they are effective because they promote a deepening of processing (Elliott & Greenberg, 1997; Wiser & Arnow, 2001). For example, Watson and Greenberg (1996) reported that two of the three process-directive tasks studied (i.e., single- and two-chair dialogues but not systematic evocative unfolding) were associated with deeper emotional and internal processing and, as well, a higher degree of resolution of the problem, relative to experiences with CCT. A recent review of process-outcome research on humanistic therapy variables indicated that the therapists’ responses do influence clients’ processing (Sachse & Elliott, 2002). Moreover, they concluded that clients rarely deepened their level of exploration unless purposefully assisted by their therapist through the use of process-directive tasks. However, Sachse and Elliott also emphasized the fundamental importance of empathy. That is, deeper exploration only occurred when clients felt understood. There was also evidence that clients tended to engage in more of the suggested tasks as therapy progressed. However, this result was moderated by the quality of the therapeutic relationship. Rennie (2002) reported similar findings.

Taken together, it appears that the judicious use of process-directive interventions, in the context of a therapeutic relationship guided by the fundamental tenets of client-centered therapy can lead to an enriched therapeutic process and potentially enhanced outcome (i.e., earlier and longer lasting effects). Further research delineating PET’s usefulness is necessary. For example, Wiser and Arnow (2001) have argued that PET is not appropriate with all clients. In particular, they suggest that it may be especially helpful for clients who historically
avoid emotional experiences. In contrast, they argue that it is not appropriate, at least initially, with clients who have difficulties regulating their emotional experiences and who are easily overwhelmed by these experiences.

**Summary**

CCT reflects Rogers’ firmly held belief that the therapeutic relationship can be growth inducing, and that the attitudes of the therapist are the critical ingredient (1951, 1980). Specifically, he argued that if therapy is to be effective, it is essential that the therapist be empathic, genuine, and unconditionally accepting of the client. Research has clearly demonstrated that CCT is an effective therapeutic intervention. However, further research is needed to determine more clearly the conditions under which CCT can be considered appropriate and/or recommended. In addition, the basis for the effectiveness of CCT needs to be examined more fully. While evidence suggests that empathy, genuineness, and acceptance are positively associated with therapeutic outcome, the evidence is not strong enough to support Rogers’ assumption that these qualities are sufficient for effective treatment. Instead, it was concluded that, at this time, the attitudinal triad, or components thereof, may be better understood as facilitative conditions for effective therapy. In this regard, the suggestion that the essence of CCT underlies the oft-reported common factor of therapy was discussed. While this notion is intriguing and there is some supporting evidence, the conclusion seems premature at this time. The possibility that CCT is a precursor to more effective or, perhaps, more efficient forms therapy was considered in the context of PET. It was concluded that the core conditions associated with CCT are essential for the use of process-directive interventions to be effective. If conducted within an empathic, genuine, and accepting relationship, these interventions are associated with enriched and deeper emotional and experiential processing by the client. Taken together, these findings suggest that the fundamental conditions associated with CCT continue to command an important role in contemporary psychotherapy.
References


