THE INTERSUBJECTIVE PERSPECTIVE AND THE CLIENT-CENTERED APPROACH: ARE THEY ONE AT THEIR CORE?

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This article reviews the change from a one-person to a two-person psychology in psychoanalysis. In particular, Robert Stolorow’s intersubjectivity theory is presented and then contrasted with the client-centered approach to therapy. It is concluded that contemporary client-centered therapy is a two-person psychology, and that well-trained client-centered therapists do reflect on their own subjectivity and how it influences the client. With their important similarities it seems that the client-centered and self psychology approaches to therapy are one at their core. Self psychology has more elaborate theorizing about the therapy process, while the client-centered approach is interested in applying its principles outside of therapy so that people can live more constructively.

For some time now there has been considerable interest in comparing Carl Rogers’s client-centered therapy with Heinz Kohut’s self psychology (Bohart, 1991; Kahn, 1985, 1989a,b; Stolorow, 1976; Tobin, 1990, 1991). Recently in psychoanalysis there has been, what has been called a paradigmatic shift (Kuhn, 1962) from a one-person psychology (with its emphasis on the psychology of the patient) to a two-person psychology (how the psychological make-up of both the patient and the therapist mutually influence each other) (Aron, 1990; Ghent, 1989). Some of the new developments in infant research (e.g., the work of Daniel Stern [1985] and Beatrice Beebe [1985]) have contributed considerably to this shift in emphasis. An important example of the two-person approach is the work of Robert Stolorow and his colleagues who have developed an intersubjective approach (see, for example, Stolorow, Atwood, & Brandchaft, 1994a; Stolorow & Atwood, 1992). Intersubjectivity theory goes a step beyond Kohut’s work by emphasizing the reciprocal interplay between the subjectivity of the patient and the subjectivity of the therapist. A primary focus of interest in Stolorow’s work is how the therapist organizes his/her experiences and the impact of that organization on the subjectivity of the patient. Stolorow has said that it is the formation of new organizing principles within an intersubjective system that constitutes the essence of developmental change throughout the life cycle.

In this article I will first summarize the one-person perspective that began with Freud, and was a product of the objectifying tradition of medical science in that era, and contrast it with the newer two-person perspective. I will also note some of the infant research that supports this shift in emphasis. I will then describe some of Kohut’s work, and contrast it with Stolorow’s more recent ideas. I will mention how Kohut (1959) brought about a major shift in psychoanalysis by defining it as the science of mental life, and then showing that mental life is accessible by only two methods, empathy and introspection. This shift was a crucial advance, since with mental life as its subject-matter, psychoanalysis could no longer define healthy functioning as a conformity to some ob-
jective reality. By placing objective reality outside the domain of psychoanalysis, Kohut was influential in bringing about a change from the one-person to a two-person psychology. I would like to stress that Kohut never denied the vital therapeutic function of empathy, as some client-centered people, including Rogers (1986b), claimed; however, a primary concern of his was to correct some of the abuses in traditional psychoanalysis, with its hidden moral and educational goals for the patient (Kohut, 1982, p. 399).

Next, I will discuss the topic of the therapist’s subjectivity, or what psychoanalysts have traditionally called countertransference. Stolorow and his coworkers have been interested in how the subjectivity of the therapist influences the subjectivity of the patient. For example, Stolorow and Atwood (1992, pp. 103-122) describe intriguing examples of therapeutic stalemates and their resolution which illustrate how the subjectivity of the therapist can importantly affect the experiences of the patient.

In light of Stolorow’s recent contributions to self psychology I will pose and, at the end of this article, attempt to answer several questions regarding client-centered therapy. The answers to these questions will indicate the extent to which client-centered therapy, at its core, is similar to self psychology. These questions are:

1. Is client-centered therapy a one-person psychology, focusing primarily on the psychology of the client, or is it a two-person, relational psychology, where the frame of reference of the therapist is considered? Is the relational aspect an important feature of the client-centered approach?

2. In the client-centered approach is the nature of the subjectivity of the therapist, that is, how the therapist organizes his/her world, sufficiently reflected upon and illuminated? In other words, do client-centered therapists become reflectively aware of how they may inadvertently influence their clients because of their own unique histories?

3. Psychoanalysts have been concerned that their own subjective truths, particularly those that derive from their theories (e.g., drives and defenses against those drives), can inadvertently influence their perception of their patients. Does the client-centered approach, too, have a theory, such as the actualizing tendency, that can color how the therapist sees the client? Or is it the very nature of client-centered theory that it tries its best to avoid harboring any preconceptions about what a client is experiencing? Is the avoidance of any preconceptions about a client’s experience one of the most important contributions of Rogers and his associates?

4. Another topic for discussion is the different therapeutic methods for Stolorow and Rogers; for example, Stolorow desires to make an active “empathic inquiry” into the subjective life of the patient so as to bring to reflective awareness how the patient organizes his/her experiences, while Rogers (1986a, pp. 207-208; Bohart, 1991, p. 41) would just want to be a companion to the client as the client makes choices and decisions, as he/she wishes.

Before going further I would like to distinguish between client-centered therapy and the person-centered approach. The person-centered approach seeks to apply the hypotheses that Rogers derived as a client-centered therapist to broader areas outside of therapy, such as international relations, education, and family relations. The central hypothesis that both client-centered therapy and the person-centered approach share is that “persons have within themselves vast resources for self-understanding and for constructive changes in ways of being and behaving and that these resources can best be released and realized in a relationship with certain definable qualities” (Rogers & Sanford, 1984, p. 1374). These definable qualities that are present in a beneficial relationship are unconditional positive regard, empathy, and genuineness.

One-Person Approach

Freud was deeply influenced by the scientific method of his day, which has been called an objectivist epistemology (Orange, 1992). Freud’s early neurological investigations and his theory of instinctual drives reflect these objectivist, natural science ideals. According to Orange (1992, pp. 193-194) empiricism is a common form of objectivism which stresses the importance of “objective reality” and “the facts.” Orange (1992) noted that in recent philosophy of science “this empiricism took the form of a demand that any theory had to meet the test of falsifiability to qualify as scientific. . . . Any theory that could not be falsified by experimental evidence had no cognitive significance” (pp. 193-194).

The concept of transference as presented by Freud in the early days of psychoanalysis was influenced by this objectivist epistemology. A major criterion of psychological health, for the
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Objectivists, was access to the facts, or reality testing. In psychoanalysis, objectivists, who primarily wanted to be scientific, claimed that transference consisted of distortions of reality or of the facts, and that these distortions can be evaluated or judged by the analyst-observer (Orange, 1992, p. 194). Proponents of this approach advocated the disciplined use of abstinence, neutrality, and a blank screen (Aron, 1990, p. 481), so that the distorted perceptions of the patient, which would manifest themselves in the transference, could be analyzed away by the "realistic" analyst.

Analysts, I am sure, also came to value neutrality and abstinence as a protection from getting emotionally overinvolved with their patients as some early analysts like Sandor Ferenczi did. As McLaughlin (1981) noted, neutrality had the benefit of affording "the analyst the protected role of detached observer vis-à-vis the intensities on both sides of the couch" (p. 659).

Aron (1991) said:

the traditional model of the analytic situation maintained the notion of neurotic patients who brought their irrational childhood wishes, defenses and conflicts into the analysis to be analyzed by relatively mature, healthy, and well-analyzed analysts who would study the patients with scientific objectivity and technical neutrality. The health, rationality, maturity, neutrality, and objectivity of the analyst were idealized, and thus countertransference was viewed as an unfortunate, but hopefully rare, lapse (p. 32).

For successful therapy to occur the patient had to change his/her reality so that it would conform to that of the analyst. Commenting on this state of affairs Schwaber (1983) said, "two realities, hierarchically arranged, remained embedded in this outlook: the one the patient experiences, and the one the analyst 'knows'" (p. 386). The therapeutic goal was to reduce to a minimum the patient's distortion of the outer world. "The aim is to help the patient gradually shift or 'correct' his view as he attains more mature functioning" (Schwaber, 1983, p. 384).

"Independence" and "autonomy" were important values in this one-person psychology. For example, Stolorow and Atwood (1992) said, in the traditional view

in the successful termination phase of an analysis the transference should be resolved or dissolved, meaning that the patient's emotional attachment to the analyst must be renounced. In this view, residual transference feelings are seen as an unfertilizing element, undermining the patient's progress toward independence (pp. 13-14).

Stolorow and Atwood (1992) commented that by emphasizing independence as a criteria for mental health, analysts sought to deny the vulnerability inherent in acknowledging the contiguity embeddedness of human experience in an intersubjective context. In other words, according to Stolorow and Atwood (1992), analysts wanted to avoid admitting "the unbearable embeddedness of being" (p. 22).

This one-person model was dominant in psychoanalysis until Kohut's ideas, starting with his 1959 paper (Kohut, 1959), helped bring about a change in outlook. Schwaber (1983, p. 380) describes the crucial change in Kohut's listening stance with his well-known patient Miss F. Kohut (1971) was trying unsuccessfully to influence Miss F by having her accept certain traditional analytic interpretations, which Kohut indicated, only infuriated her. Kohut (1971) then said:

It was ultimately, I believe, the high-pitched tone of her voice which led me on the right track. I realized that it expressed an uner conviction of being right—the conviction of a very young child—which had heretofore never found expression. Whenever I did more (or less) than provide simple approval or confirmation in response to the patient's reports of her own discoveries. I became for her the depressive mother who . . . deflected the narcissistic cathexes from the child upon herself, or who did not provide the needed narcissistic echo. Or I became the brother who, as she felt, twisted her thoughts and put himself into the limelight (p. 288).

Schwaber (1983, p. 381) said she felt that Kohut's most creative contribution was the shift in his listening stance. that is, his desire to make a sustained effort to listen from the patient's perspective. Schwaber (1983) commented that, as therapists, we have

to find a way, from deeply within ourselves, to come to terms with the idea that we do not know one more 'true' reality and that the patient's view, even about us, is as real as the one we believe about ourselves (p. 390).

I would like to remark, at this point, how far ahead of the psychoanalysts Rogers was in appreciating the validity of the subjectivity of the client. It is remarkable that it is only relatively recently, as a result of Kohut and others, that psychoanalysts are coming to realize that the patient's view of reality is as legitimate as the analyst's view. And, as client-centered people appreciate, this is what Rogers was saying as far back as the early 1940s (Rogers, 1942).

Two-Person Approach

There has been a change in the world of physics generated by the discoveries in quantum physics (Sucharov, 1994). In classical physics there was a sharp separation between the observer and the
observed, which led to a scientific objectivity independent of any observational stance. In the new physics of Einstein, Planck, and Heisenberg "the field that is observed, of necessity, includes the observer" (Kohut, 1984, p. 41), which leads to a relativity of perception, and in principle, the absence of an objective reality (Kohut, 1984, p. 36).

Associated with the changes in physics, there have been important changes in other disciplines, such as psychoanalysis. Kohut (1984, p. 41) contributed to the changes with his appreciation that there is a continual impact of the observer and his/her theories on what is being observed. Stolorow, Atwood, and Brandchaft (1994b), in describing the new paradigm that is evolving, said "it is not the isolated individual mind . . . but the larger system created by the mutual interplay between the subjective worlds of patient and analyst, or of child and caregiver, that constitutes the proper domain of psychoanalytic inquiry" (p. x). In this relational paradigm "transference and counter-transference together form an intersubjective system of reciprocal mutual influence" (Stolorow, 1994, p. 10), and there is an appreciation that "each participant's reaction is a product of his/her construal of the cues communicated by the other" (Eagle, 1993, p. 102fn).

Infant research has made an important contribution to this two-person approach (Beebe & Lachmann, 1992). For example, Winnicott had once said "there is no such thing as an infant" (quoted in Becal, 1989, p. 260). He obviously meant that without maternal care there would be no infant. Today's infant research has clearly demonstrated how the child's capacity for self-regulation is based, not on the child alone, but on the dyad, that is, the child-caregiver system of mutual regulation (Beebe & Lachmann, 1988). Beebe and Lachmann (1988) note that what is cognitively represented in the infant "is not simply interiorized action, but interiorized interaction: not simply the infant's action, nor simply the environment's response, but the dynamic mutual influence between the two" (p. 8).

As a result of this shift in emphasis, the analyst now must pay closer attention to his/her contribution to the patient's reactions. For example, Aron (1990) commented, "the implication of a two-person psychology is that who the analyst is . . . his/her very character, makes a real difference for the analysand" (p. 479). And Thomson (1994), in describing Stolorow's intersubjectivity theory, says it "places special emphasis on the examination of the minute and subtle effects of the analyst's real presence and interventions as subjectively experienced by the patient" (p. 132).

Stolorow, Atwood, and Brandchaft (1994b) note that this new paradigm allows the analyst much greater flexibility to explore new modes of therapeutic intervention "so long as the analyst consistently investigates the impact of his techniques, style, and theoretical assumptions on the patient's experience and on the course of the therapeutic process" (p. xi). Also with this two-person, relational paradigm, neither participant has a privileged view of reality (Stolorow, Atwood, & Brandchaft, 1994b, pp. xi).

This change in psychoanalysis from a one-person to a two-person psychology aptly illustrates what Kuhn (1962) described as a paradigm crisis and shift. Kuhn (1962, pp. 74-75) said, "a novel theory emerged only after a prolonged failure in the normal problem-solving activity" of the earlier paradigm. With the one-person paradigm a serious crisis, with considerable malaise (see Kuhn, 1962, pp. 82-84), existed, for example, patients were drawn into conflict with analysts about the nature of reality, patients were blamed for resisting analytic interpretations (as in "negative therapeutic reactions"), power was unevenly distributed, and therapeutic stalemates were common. Furthermore, in Rogers's work, the subjectivity of the client was appreciated in a way that a one-person paradigm, focused on objective reality, didn't permit. With the new two-person paradigm, the above conflicts eased and therapeutic effectiveness in psychoanalysis has been enhanced.

Kohut and Stolorow

Kohut was interested in psychological states in which the structure that organizes the experience of self is weak or unsteady, that is, where developmental misattunements have arrested personality growth. The concept of a "selfobject" is important in Kohut's theorizing (Trop, 1994, pp. 77-78). A "selfobject" is the experience of another person who is completely attuned to the needs of one's "self." According to Kohut, self-object experiences in the therapeutic relationship correct developmental deficits and allow the organization of the self to become stronger and more cohesive. Therapeutic growth, for Kohut, was not associated with becoming more independent, as it was for the classical analysts. but rather with acquiring the ability to seek out and establish self-
object experiences on a mature, adult level. Kohut (1984) said “the essence of the psychoanalytic cure resides in a patient’s newly acquired ability to identify and seek out appropriate selfobjects—both mirroring and idealizable—as they present themselves in his realistic surroundings and to be sustained by them” (p. 77).

As noted, Kohut defined psychoanalysis as the study of mental life, and the two ways to have access to mental life is through introspection and vicarious introspection, which is empathy. Kohut (1984) defined empathy as “the capacity to think and feel oneself into the inner life of another person” (p. 82). Stolorow (1994), also, used “the empathic-introspective mode of investigation as defining and delimiting the domain of psychoanalytic inquiry” (p. 34fn).

Stolorow’s intersubjectivity theory, I believe, expands and elucidates aspects of Kohut’s work. Stolorow theorized that each of us establishes in our personality unique organizing principles that automatically and unconsciously shape our experiences. These organizing principles, which are usually not reflected upon, develop during childhood in the interactional system of the child and the caretaker. Once established these organizing principles influence adult functioning. For example, if a person enters a room with unfamiliar people, and someone immediately turns his back, different people experience this back turning in different ways (Trop, 1994, p. 78). One person might experience it as meaning that he is undesirable and repugnant. Another might think he is better than anyone and assume a haughty indifference. A third person might think that the back turning had nothing to do with his entering the room. According to Trop (1994), “each person will automatically organize experience according to the unique psychological principles that unconsciously shape his subjective world” (p. 78).

Psychoanalysis, for Stolorow, by using the method of “empathic inquiry,” is a way to illuminate and restructure this prereflective unconscious. Stolorow also emphasizes that, as part of the empathic inquiry, it is essential for the analyst to continually reflect upon the involvement of his/her own subjectivity in the therapeutic interaction. Trop (1994), in describing Stolorow’s therapeutic approach, said

the presence of a background selfobject transference tie with the analyst provides a trusting relationship for the investigation and illumination of the old repetitive organizing principles. . . . The new selfobject experience with the analyst fa-

cilitates the development of new, alternative organizing principles and a capacity for self-reflection. Thus the essence of cure within intersubjectivity theory lies in the acquisition of new principles of organizing experience (p. 80).

And Stolorow, Atwood, and Brandchaft (1992) described their approach in the following way:

such analysis, from a position within the patient’s subjective frame of reference, always keeping in view the codetermining impact of the analyst on the organization of the patient’s experience. . . . facilitates the. . . expansion of the patient’s capacity for self-reflection and gradually establishes the analyst as an understanding presence to whom the patient’s formerly invariant ordering must accommodate, inviting syntheses of alternative modes of experiencing self and other (p. 29).

Countertransference

In the psychoanalytic literature there is a narrow and more inclusive meaning of the term countertransference. The broad conception of countertransference refers to the whole of the subjective experience of the therapist. The narrow definition of countertransference refers to the aspects of the therapist’s personality that interferes with empathic understanding and optimal responsiveness (Orange, 1994, p. 185).

Kohut (1971) used the more narrow definition of countertransference. For example, he said “we must . . . recognize our countertransference and thus minimize the influence of factors that distort our perception of the analysand’s communications and of his personality” (Kohut, 1984, p. 37). Kohut (1971) reported, as an example of countertransference, “the tendency of some analysts . . . to respond with erroneous or premature or otherwise faulty interpretations when they are idealized by their patients” (p. 138). In line with the two-person approach Schwaber (1993) defined countertransference as “reflecting a retreat from the patient’s vantage point toward an added certainty in the correctness of one’s own” (p. 1051). On the other hand, Stolorow has used the wider definition of countertransference as the totality of the analyst’s psychological structures and organizing activity.

Several writers have commented on the lack of study of countertransference in the psychoanalytic literature (Orange, 1994; Schwaber, 1983, p. 381; Thomson, 1994). For example, Orange (1994) said, “where, then are the discussions of the analyst’s organizing activity, history, and personality in our case reports? Why are many of us still writing as if the analytic patient were the only one organizing or reorganizing experience” (pp. 179-180)? Orange (1994) also observed:
Agree with John Shlien’s (1987) criticism of the transference concept. Shlien argued that transference is a fiction since the reason the client gets angry at or falls in love with the therapist always has something to do with the way the therapist has acted. Self psychologists are now essentially agreeing with Shlien when they say that, in their mutual interaction, everything about the therapist is influencing the client, and vice versa. Thus, with the two-person paradigm, the idea of transference as a distortion disappears.

Some Examples

In this section I will present examples of how the subjectivity of the therapist can unknowingly influence the patient in ways that may interfere with therapeutic progress. I will conclude by summarizing one of the case reports from Stolorow and Atwood’s (1992, pp. 103-122) chapter on this topic.

(1) Stolorow, Brandchaft, and Atwood (1987, p. 113) cite a movie episode described by Kember (1975, pp. 245-246) where a nurse, who is a decent young woman, is taking care of a very destructive and severely ill patient. The patient treats the nurse coldly and with unscrupulous exploitation, and, as a result, the nurse develops a hatred for her patient. Dramatically, the nurse retaliates by mistreating her patient cruelly. Stolorow, Brandchaft, and Atwood (1987) comment that the nurse needed at least some caring responsiveness from her patient in order to regulate her psychological well-being. When her psychological needs were repeatedly frustrated, the nurse’s narcissistic vulnerability triggered her cruelty. Stolorow, Brandchaft, and Atwood (1987) then say, “we have observed such factors at work in ourselves and regard them as to some degree universal in therapeutic relationships” (p. 114). In other words, therapists are not above being narcissistically injured, and that unconscious retaliatory actions toward clients in situations where the therapist’s self has been wounded may be more common than acknowledged.

(2) I had a client who was quite challenging for me. She gave up her marriage with a conventional and, according to her, controlling and unloving husband who wanted her back, and began a series of relationships with younger, racially and culturally different, and for a time in my mind, inappropriate men, who were rejecting and hurting her deeply. It was hard for me to decenter from what I thought would be best for her. Could it be, by
my suggestion of a practical solution to her life problems, which she didn’t want—couples therapy for her and her husband—I was trying to avoid having to hear and also experience with her the depths of her inner suffering and suicidal hopelessness?

(3) Schwaber (1983, pp. 389-390) describes what she thinks is a universal resistance “to the acknowledgment that the truth we believe about ourselves is no more (though no less) ‘real’ than the patient’s view of us—that all that we can ‘know’ of ourselves is our own psychic reality” (p. 389).

An example of this kind of resistance is when a therapist believes he/she has been helpful and caring, but the patient’s view is completely different. For example, Thomson (1994, pp. 128-129) describes an episode where a patient's friend died from leukemia. Thomson believed that it was hard for him to distance from his belief that he had been only kind. However, Thomson does eventually realize that, because of his classical analytic training, he may not have been as compassionate as his patient wished. Thomson (1994) remarks that “ultimately, the analyst, by means of inner processing, may be able to convert his anger, hurt, or other aversive reactions into signals so that they no longer block access to the kernels of truth in the patient’s observations” (p. 135).

Schwaber (1983) comments eloquently on this issue. She said, in discussing two of her patients:

I felt that I had been making every ‘reasonable’ effort to attune to their worlds; if they then did not see me that way, it was their neuroses which caused them to misperceive, preventing them from attaining a more ‘realistic’ view. When I recognized that from their vantage point, there is another way to experience my responses to them, and that I cannot be the arbiter of which is the more valid—theirs or mine—I shifted my mode of attunement and was led on to a path of discovery of dimensions of their inner world hitherto unknown (p. 390).

On the same issue, Schwaber (1993) said “I have observed more generally that a feeling of struggle with a patient, however scarcely and subtly perceived within ourselves, may be a salient indicator that we are trying to guide the patient to see it our way” (p. 1049).

(4) A therapist’s constructive interpretation can sometimes be even hurtful to a patient. Brandchaft and Stolorow (1994) describe an incident where a patient, Mr. J., came to a session very excited with a set of papers he prepared that chronicled insights he discovered over the week-end about his early relationship with his father. The analyst, fascinated with Mr. J’s insights, and eager to make the most of the opportunity, added some relevant explanations of his own. The session continued, but Mr. J., who had been enthusiastic and full of animation at the beginning of the session, now began to sound increasingly dull, repetitive, and uninspired. The analyst noted the change and inquired as to whether the patient was aware of it and whether he could account for it. Thereupon Mr. J. exploded: “You are just like my father—that is exactly what I was writing about. He could never just be pleased with how I was or what I did; he kept showing me and telling me how much better, smarter, and ahead of me he was, how much better a son he had been to his mother than I, what great things he could have accomplished if only he had had the glorious opportunities he was providing me with!” (p. 102).

(5) Stolorow and Atwood (1992, pp. 103-122) describe several fascinating examples of therapeutic stalemates that are caused by a lack of reflective self-awareness on the part of the therapist. I will paraphrase one example (see pp. 114-121) to illustrate. In this example, difficulties began when the therapist informed his patient, Sarah, of a summer vacation he was planning to take. Sarah became very upset with this news and almost ended therapy. What was most upsetting to Sarah was not the actual separation, but rather her perception that the therapist did not comprehend the extent of the “sadness and despair his departure was triggering” (p. 118). The therapist mostly reassured Sarah that she would be all right while he was away. Sarah felt that her therapist did not fully understand the frightened and vulnerable child she experienced herself as being. The therapist, while working with Sarah, was learning more about himself from his own personal therapy. He, too, experienced a child-self that had been responded to insufficiently. The therapist grew up “in a family that was profoundly affected by the sudden death of his mother when he was eight years old” (p. 118). In his own therapy, the therapist was experiencing more fully his own vulnerable child-self that had always been denied expression. As he began to change, his understanding of Sarah changed too. He came to realize that “separations were simply impossible for the child within her to manage” (p. 119), and that Sarah needed a response from him showing he understood this fact. He also realized that his repeated reassurances that she could manage, felt to Sarah as “rejections of her child-self” (p. 119). The therapist, by working through his denial of the child in him, was
able “to make empathic contact with the traumatized child-self” (p. 121) of Sarah, and the therapy with her resumed productively.

Discussion

I will now attempt to answer the questions posed at the beginning of this article about client-centered therapy. The answers to these questions will indicate the extent of the core compatibility of the client-centered and self psychological approaches. Obviously giving unbiased and concise answers to these questions is not a simple and uncomplicated task.

(1) Is client-centered therapy a one-person psychology, focusing primarily on the psychology of the client, as when reflecting a client’s feelings, or is it a two-person relational psychology, where the therapist as a person is involved in the therapeutic relationship?

Clearly Rogers’s way of interacting changed, over time, from a more formal, professional attitude to a more relaxed, spontaneous and human way of relating (Broder, 1994). At the inception of client-centered therapy, from about 1938 until the late 1940s, the focus was on the framework of the client, and less attention was paid to the person of the therapist. For example, Rogers and Sanford (1984) say about client-centered therapy during that time period, “reflection of feeling and nondirective techniques were its main identifying marks so far as the professional world was concerned” (p. 1374). Kirschenbaum (1979) has said of this time period, “technique was the thing. Just as free association was the primary technique for the classical psychoanalyst, reflection of feelings was the primary technique to Rogers, the key to the whole process, the source of all growth in nondirective therapy” (p. 136). Thorne (1992, p. 88) also commented about the “non-relational” aspect of Rogers’s early work.

Regarding this issue, Raskin (personal communication, August 30, 1995) said:

During the years at Ohio State and World War II [1940-1944] the therapist as a person in the therapeutic relationship was not conceptualized. At the same time, reflection of feeling was never used as just a technique. The term was used more by people outside of or opposed to the approach to represent a mechanical way of responding. Within the orientation, “recognition and appreciation of feeling” was a much more characteristic phrase and was seen as a way of implementing a deep conviction about the capacity of the client to find his own direction, with facilitation rather than guidance.

Raskin believes that the involvement “of the therapist in the relationship changed radically soon after Rogers arrived at the University of Chicago in 1945.” With two graduate students, Oliver Bown and Eugene Streich, Rogers began to describe the “therapist as entering into the relationship in a much more full and personal manner” (Raskin, personal communication, August 30, 1995).

In addition to Rogers’s work with graduate students at the University of Chicago, three other factors may have helped Rogers, over time, to use more of his own self in the therapeutic interaction. These other factors were: (a) the “Wisconsin project” of the late 1950s with schizophrenic patients which “gave rise to an increased emphasis on the therapist’s use of his own thoughts and feelings in order to establish contact with persons” who were mostly uncommunicative (Kirschenbaum, 1979, p. 277; Thorne, 1992, pp. 83-84), (b) the dialogue with Martin Buber, in 1957, on “I-thou” interactions, which emphasized a “real reciprocity” in relationships (Thorne, 1992, pp. 69-70, 83-84), and, probably, most importantly (Raskin, personal communication, August 30, 1995), (c) the intensive group experiences of his California years (after 1963) which Rogers participated in regularly (see also Thorne, 1992, p. 84).

By the 1980s Rogers was saying that genuineness or congruence was the most important and basic of the three necessary and sufficient conditions (Rogers & Sanford, 1984, p. 1378). Also in the 1980s, when responding to a questioner in the audience on what the profession of psychotherapy has learned over the past 100 years, Rogers (1985) said, “I don’t know what the profession has learned, I really don’t. I’ve learned to be more human in the relationship, but I am not sure that that’s the direction the profession is going.”

Broder (1994), in a detailed analysis of the actual verbatim transcripts of Rogers therapy behavior, found that “Rogers expressed responses from his own frame of reference more frequently during the final, 1977-1986, phase of his work than in the earlier, 1944-1964 phase” (p. 46). She found an increase in Rogers’s responses, spoken from his own frame of reference, from 4% in the earlier period to 16% in the later period. Despite these findings Broder (personal communication, July 23, 1995) disagrees that Rogers shifted from a one-person to a two-person psychology. She says:

I have been a client-centered therapist for 40 years now—so in the beginning I was going on what had been written . . . and my understanding was always that the relationship was
the means of contributing to the client's change. . . . In my opinion the change was not from 1 to 2 person at all, but from a less free to a more free person in the case of Rogers . . . but the theory from early 1942 was definitely about a relationship and for those of us who didn't have to overcome the earlier constraints it was immediately a very spontaneous person to person relationship. Of course, there are always individual differences.

According to Brodley (personal communication, July 23, 1995), the constraints on Rogers in the 1940s that had to be overcome were that Rogers "was still very much a clinical psychologist with the formality of that role," and also that he was influenced by the psychoanalytic concerns of that time period which emphasized restraint. Whether or not Rogers's approach was a two-person psychology in the 1940s, it can be agreed that today, with its emphasis on humanness and congruence, client-centered therapy is a relational, two-person approach.

(2) Is there sufficient interest, in the client-centered approach, on how the subjectivity of the therapist influences the subjectivity of the client? For example, do client-centered therapists become reflectively aware of how they may inadvertently influence their clients because of their own unique histories?

Stolorow emphasizes, as part of his analytic approach, that it is essential for the therapist to continually reflect upon the involvement of his/her own subjectivity in the therapeutic interaction. I have wondered whether client-centered therapists reflect sufficiently on their own subjective experiences. For example, I haven't read in the client-centered literature, as I have for self psychology (Stolorow & Atwood, 1992, pp. 103-122), specific examples of how the psychological biases of the therapist can influence the client. Furthermore, on different occasions, Rogers (e.g., 1986b) indicated that he used his "intuition" in being congruent and genuine. I wondered whether the term "intuition" in psychotherapy is similar to the term "instinct" in biology. Just as it is helpful to understand the physiological origins of an "instinct," it may be important to understand the psychological origins of an "intuition." And to me Rogers never seemed inclined to explore the psychological origins of his intuitions.

I have also wondered whether Rogers had biases that led him to believe in mainly short-term therapy (C. R. Rogers, personal communication, August 23, 1983). For example, Rogers & Sanford (1984) said, "on the whole, the duration of client-centered therapy is relatively short compared to that of a number of other therapies" (p. 1381). Was Rogers interested mainly in short-term therapy because he was having more impact outside of the therapeutic field in the area of social action? Or was his interest in short-term therapy a criticism of the inefficiency of psychoanalysis as a therapeutic method? Did he have the interest to work with a client over a longer period of time?

Other client-centered therapists have indicated that they do work long-term with clients (B. T. Brodley, personal communication, August 12, 1995; Raskin, 1986).

Tobin (1991) offered an interesting explanation of Rogers's interest in short-term therapy. Tobin (1991) said that Rogers "seemed to have been very concerned about people becoming too dependent on the therapist and staying dependent" (p. 26). Tobin thought that Rogers "may have been shaped by his advocacy of what is a questionable Western cultural belief: That growth is always in the direction of greater independence and separation" (p. 26). Tobin felt that Rogers may not have "recognized sufficiently that many clients actually need to allow themselves to have a dependent, childlike tie to the therapist in the early stages of therapy to be able to grow and mature into adult interdependence" (p. 27).

Regarding the self-reflective attitude of the client-centered approach, Brodley (personal communication, July 23, 1995) disagrees with me. She said:

When you are striving to purely understand, and are sincerely responsive and accepting towards the client's corrections, and are also sincerely accepting towards the person, the ways your empathic understandings are influenced by your own biases become evident to you—both because you are sensitized to contaminations in trying to be pure, and because your client either corrects the ways you are adding to what they are trying to express, or the client recognizes that you are pushing some view and comments on it.

In my work as a consultant/supervisor, I meet with many client-centered therapists. The focus of such meetings has to do with the therapist's direct reflections on their biases, histories, feelings, reactions that are interfering with their purity. This extreme focus on one's self as an influence is... part of the essence of the meaning of congruence in client-centered therapy.

From Brodley's comments, at least in theory, it does appear that a well-trained client-centered therapist will reflect continuously on the involvement of his/her subjective experience in the therapeutic interaction.

(3) Psychoanalysts are concerned that their theories inadvertently influence their perception of
their patients. Does the Regerian approach, too, have a theory that can color how the therapist sees the client? Or is it the very nature of client-centered theory that it attempts to avoid harboring any preconceptions about clients?

A major strength of the client-centered approach, compared to Freudian psychoanalysis, is that its specific goal is to avoid harboring any preconceptions about the subjective experiences of clients. Freudian psychoanalysis, with its theory of instinctual drives and repressed wishes, had preconceived hypotheses about unconscious dynamic forces within a patient's psyche. Patients were made aware of these unconscious motivators of behavior via the interpretations of the analyst.

Although the client-centered approach avoids speculating about what a client is experiencing either consciously or unconsciously, it has a theory that colors how the client as a person is perceived. The major preconceptions of client-centered theory are the actualizing tendency, that is, the positive and trustworthy basis of human nature, and the three necessary and sufficient conditions. Brodley (personal communication, July 23, 1995), in commenting about the theoretical biases of the client-centered approach, said:

The emphasis on unconditional positive regard is a fundamental theoretical element that very basically influences the way clients are perceived. Specifically—if the attitude towards the client is a-priori accepting, and the aim is empathic understanding of the client's immediate inner experience, then many possible viewpoints about the person are put aside or not experienced.

To clarify, Brodley adds (personal communication, August 12, 1995),

I do not think that client-centered work in any sense makes us less realistic about the client's weaknesses or shortcomings or bad behavior. . . . I do not think we are biased away from negative things about the person, nor do we behave in ways that keep the client from those [negative] things. Basic to the approach is the perception that providing the non-suspicious, non-interpretive, acceptant understanding that we strive for does, in fact, more quickly and accurately bring out the truth of the client's "badness."

Brodley (personal communication, August 12, 1995) concludes that the "bias" of viewing "the client in a trusting and constructive light" works "to bring out more truth, faster and in ways that strengthen the person" as the truth comes out. I might also add that with such empathic understanding the client's "badness" may not seem so "bad" after all.

Different critics of the client-centered approach, such as Rollo May (1982), have taken issue with Rogers for his supposed biased optimistic perception of human nature. It is to be noted that Kohut, too, had an optimistic philosophy about human nature. For example, Kohut (1982) said:

"It is only when the self of the parent is not a normal, healthy self, cohesive, vigorous, and harmonious, that it will react with competitiveness and seductiveness rather than with pride and affection when the child, at the age of 5, is making an exhilarating move toward a hereafter not achieved degree of assertiveness, generosity, and affection. And it is in response to such a flawed parental self . . . that the newly constituted assertive-affectionate self of the child disintegrates and that the break-up products of hostility and lust of the Oedipus complex make their appearance" (p. 404).

Thus, Kohut, although he uses a very different language, has the same basic idea as Rogers: that there is an innate growth tendency in the organism which can get sidetracked when a parent, because of defects in the parent's personality, does not respond in an attuned way toward the child's developing self.

(4) As a psychoanalyst, Stolorow wishes to make an "empathic inquiry" into the subjective life of the patient in order to bring to reflective awareness how the patient organizes his/her experiences. Rogers, on the other hand, wanted to just be a companion to the client as the client discusses his/her life (Bohart, 1991, p. 41; Rogers, 1986a, pp. 207-208). Stolorow, in making an active exploration of subjective experiences, seems to be taking more of an initiative than Rogers: Raskin (personal communication, August 30, 1995) disagrees with Stolorow's approach. Raskin says,

I don't want to decide what the client needs to explore, in order to help him. He sets the agenda. What Stolorow feels is necessary to be helpful can impose something really big on the client, and can really slow things down and/or lengthen the course of therapy.

It is to be noted that within the self psychology field there has been some disagreement on this issue; for example, Miller (1988) preferred the term "empathic immersion," which is more like Rogers's style, to Stolorow's "empathic inquiry." Furthermore, on different occasions Rogers noted that, within the client-centered approach, there are different styles of doing therapy based on the personality of the therapist. The fact that Stolorow feels more comfortable initiating an empathic inquiry, while Rogers preferred being a companion to the client may make little difference in the effectiveness of the therapy. As Stolorow, Atwood, and Brandchaft (1994b, p. xi) commented, a two-person psychology allows for more flexi-
bility so long as the therapist continually investigates the impact of his/her interventions on the patient's experiences.

Conclusions

With its emphasis on listening to the subjectivity of the client, without theoretical preconceptions, the client-centered approach made, perhaps, its most important contribution. Psychoanalysts, until the time of Kohut, tried to impose interpretations on patients, that patients often "resisted" accepting. Defense and resistance became important topics in psychoanalytic theorizing, probably because of untimely interpretations. It appears that the imposing of interpretations in psychoanalysis has diminished significantly as a result of Kohut's writings. As noted earlier, it was only after a great struggle that Kohut gave up his belief that his interpretations were always helpful to his patients. For example, in his final work Kohut (1984) said:

"The patient, as I finally grasped, insisted—and had a right to insist—that I learn to see things exclusively in his way and not at all in my way. And as we finally came to see—or rather as I finally came to see, since the patient had seen it all along—the content of all my various interpretations had been cognitively correct but incomplete in a decisive direction. . . . What I had not seen, however, was that the patient had felt additionally traumatized by feeling that all these explanations on my part came only from the outside: that I did not fully feel what he felt, that I gave him words but not real understanding, and that I thereby repeated the essential trauma of his early life (p. 182).

This attitude of attempting to just listen to what the client is experiencing is the attitude that Rogers was advocating as early as the 1940s. For example, Rogers in 1942 said:

"This course of action imposes much self-restraint upon the counselor. The reason is simple. As the client reveals himself more and more fully in the counseling interviews, the counselor begins to develop insight into the client's problems. . . . There is the greatest temptation to most counselors, whether they are psychiatrists, psychologists, guidance counselors, or social workers, to inform the client as to his patterns, to interpret his actions and his personality to him. . . . The more accurate the interpretation, the more likely it is to encounter defensive resistance. The counselor and his interpretations become something to be feared. To resist this temptation to interpret too quickly, to recognize that insight is an experience which is achieved, not an experience which can be imposed, is an important step in progress for the counselor (Rogers, 1942, pp. 195-196).

It seems that Kohut, in the 1980s, was still discussing this same issue.

Another important contribution, I believe, of the client-centered approach is its democratic attitude. Carl Rogers espoused the ideals of compas-
apy, such as to education, parenting, business, race relations, poverty, medicine, and international relations, to name some of the areas of interest. Ruth Sanford (personal communication, July 16, 1995) before leaving for South Africa, to conduct person-centered seminars, quoted Rogers as saying “I am amazed at the impact that this approach has had in many parts of the world and I believe it must be an idea whose time has come.”

In the therapy situation, the use of the term “client,” along with the democratic attitude of the therapist, in the client-centered approach, helps minimize the inequality that inevitably exists in every therapeutic relationship. In fact, Bozarth (personal communication, July, 1995) said he wants to discontinue the use of the term “client,” which can also be a dehumanizing label; he would prefer to call the individual who is receiving therapy, a “person.” He would prefer to call “client-centered therapy,” “person-centered therapy.” There is a pertinent quote by Irvin Yalom (1989) in his book “Love’s Executioner” that fits perfectly with the Regerian philosophy regarding the people who seek therapy. Yalom (1989) says:

Though these tales of psychotherapy abound with the words patient and therapist, do not be misled by such terms: these are everyman, everywoman stories. Patienthood is ubiquitous; the assumption of the label is largely arbitrary and often dependent more on cultural, educational, and economic factors than on the severity of pathology. Since therapists, no less than patients, must confront these givens of existence, the professional posture of disinterested objectivity, so necessary to scientific method, is inappropriate. We psychotherapists simply cannot cluck with sympathy and exhort patients to struggle resolutely with their problems. We cannot say to them you and your problems, because our life, our existence, will always be riveted to death, love to loss, freedom to fear, and growth to separation. We are, all of us, in this together (p. 14).

Rogers’s attitude toward the therapeutic encounter seems to be fully in tune with Yalom’s sentiments.

Final Remarks

After writing this article, I have begun to think that at their core the client-centered and self psychology approaches to psychotherapy are one. The self psychology approach has more clothes on, is dressed up in more elaborate theorizing about selfobjects, mirror transferences, idealizing needs, organizing principles, narcissistic and oedipal fixations, and so on. What is basic to both approaches is respect for the subjectivity of the other, the valuing of the personhood of the other, and the genuine encounter between two people where the subjectivity of each is reflected upon. The self psychological approach may be more hierarchical and less democratic (both professionals and nonprofessionals have equal status at client-centered meetings); but self psychology also provides more interesting speculation about the person with its more elaborate theoretical formulations and insights about psychological development.

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