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The Intersubjective Perspective and the Client Centered Approach: Are They One at Their Core?

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Abstract

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

Keywords: *intersubjectivity theory, self psychology, therapy process, two person psychology.*

For some time now there has been considerable interest in comparing Carl Rogers's clientcentered therapy with Heinz Kohut's self psychology (Bohart, 1991; Kahn, 1985, 1989a, 1989b; Stolorow, 1976; Tobin, 1990, 1991). Recently in the psychoanalytic literature there has been, what has been called, a paradigmatic shift from a oneperson psychology (with its emphasis on the psychology of the patient) to a twoperson psychology (how the psychological makeup 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 twoperson 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 or 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 paper I will first summarize the oneperson perspective that began with Freud, and was a product the objectifying tradition of medical science in that era, and contrast it with the newer twoperson 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 subjectmatter, psychoanalysts could no longer define healthy functioning as a conformity to some objective reality. By placing objective reality outside the domain of psychoanalysis, Kohut was influential in bringing about a change from the oneperson to a twoperson psychology. I would like to stress that Kohut never denied the vital therapeutic function of empathy, as some clientcentered 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 & Atwood (1992, pp. 103122) describe intriguing examples of therapeutic stalemates and their resolution which illu-

strate 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 the paper, attempt to answer several questions regarding clientcentered therapy. The answers to these questions will indicate the extent to which clientcentered therapy, at its core, is similar to self psychology. These questions are:

1 Is clientcentered therapy a oneperson psychology, focusing primarily on the psychology of the client, or is it a twoperson, relational psychology, where the frame of reference of the therapist is considered? Is the relational aspect an important feature of the clientcentered approach?
2 In the clientcentered approach is the nature of the subjectivity of the therapist, that is, how the therapist organizes his or her world, sufficiently reflected upon and illuminated? In other words, do clientcentered 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 clientcentered 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 clientcentered 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 or her experiences, while Rogers (1986a, pp. 207208; Bohart, 1991, p. 41) would just want to be a companion to the client as the client makes choices and decisions, as he or she wishes.

Before going further I would like to distinguish between clientcentered therapy and the personcentered approach. The personcentered approach seeks to apply the hypotheses that Rogers derived as a clientcentered therapist to broader areas outside of therapy, such as international relations, education, and family relations. The central hypothesis that both clientcentered therapy and the personcentered approach share is that "persons have within themselves vast resources for selfunderstanding 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.

OnePerson 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. 193194) 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. 193194).

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 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 analystobserver (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 á 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 wellanalyzed 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 or 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 oneperson psychology. For example, Stolorow & 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 infantilizing element, undermining the patient's progress toward independence (pp. 1314).

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

This oneperson 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 wellknown 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 highpitched tone of her voice which led me on the right track. I realized that it expressed an utter 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 clientcentered people appreciate, this is what Rogers was saying as far back as the early 1940s (Rogers, 1942).

TwoPerson 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 or her theories on what is being observed. Stolorow, Atwood, & 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 countertransference 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 or her construal of the cues communicated by the other" (Eagle, 1993, p. 102fn).

Infant research has made an important contribution to this twoperson 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 selfregulation is based, not on the child alone, but on the dyad, that is, the childcaregiver system of mutual regulation (Beebe & Lachmann, 1988). Beebe & 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 or 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 or 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, & 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 twoperson, relational paradigm, neither participant has a privileged view of reality (Stolorow, Atwood, & Brandchaft, 1994b, pp. xi).

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. 7778). A "selfobject" is the experience of another person who is completely attuned to the needs of one's "self." According to Kohut, selfobject 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 selfobject 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 empathicintrospective 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 or 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 facilitates the development of new, alternative organizing principles and a capacity for selfreflection. Thus the essence of cure within intersubjectivity theory lies in the acquisition of new principles of organizing experience (p. 80).

And Stolorow, Atwood, & Brandchaft (1992) describe 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 selfreflection and gradually establishes the analyst as an understanding presence to whom the patient's formerly invariant ordering principles 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 twoperson 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 (Thomson, 1994; Orange, 1994; Schwaber, 1983, p. 381). 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:

With a few notable exceptions ... we self psychologists are, I think, so involved in and devoted to our efforts to get and stay close to the patient's experience that we often forget that we are there too. Thus, our cherished effort to understand patients from their own vantage point may prevent us from recognizing our contribution to shaping the patient's experience (the influence of the observer on the observed). It may also interfere with our recognizing that we can understand another's experience only through our own equally subjective experience (p. 180).

Orange (1994) then quotes Lomas in 1987 in the following way:

By the very nature of things people cannot attain perfect openness to each other. Our perceptions are based on past experience. Nothing is entirely new to us ... . However much we strive toward an unencumbered, receptive state of mind, we bring to each exchange the sum total of our history, an interpretation that is unique to us (p. 180).

As examples of our history influencing us Eagle (1993) mentioned "those aspects of countertransference that are expressed subtly through such dimensions as vocal qualities, ways of listening, choice and tone of interpretations, choice of material on which to focus, decisions regarding termination, and so on" (p. 102ff).

Aron (1991) has been critical of the term "countertransference" (see also McLaughlin, 1981, p. 655). He said:

Thinking of the analyst's experience as 'counter' or responsive to the patient's transference encourages the belief that the analyst's experience is reactive rather than subjective, emanating from the center of the analyst's psychic self. ... The term countertransference ... obscures the recognition that the analyst is often the initiator of the interactional sequences, and therefore the term minimizes the impact of the analyst's behavior on the transference (p. 33).

Orange (1994) agrees with this criticism and suggests "cotransference would better acknowledge our participation with the patient in the intersubjective field ... of the psychoanalytic dialogue" (p. 180).

Orange (1994, pp. 181-185) also presents a philosphical discussion of prejudice, which is fascinating, noting that prejudice is inevitable, since everyone has a point of view or perspective. She comments that the philospher Gadamer sought to remove the negative connonnotations from the word prejudice. Orange (1994) then says:

we must know and acknowledge our countertransference, our cotransference, our point of view or perspective, if we are to become capable of empathy ... . We must acknowledge the lenses through which we are reading the text in order to do authentic psychoanalytic work (p. 183).

From the above remarks it can be seen that in different ways self psychologists are coming to 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 twoperson 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. 103122) chapter on this topic.

1 Stolorow, Brandchaft, & Atwood (1987, p. 113) cite an anecdote from a movie described by Kernberg (1975, pp. 245246) 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 an intense hatred for her patient. In a dramatic development, the nurse mistreats her patient cruelly. Stolorow, Brandchaft, & Atwood comment that the nurse needed some kind of caring responsiveness from her patient in order to regulate her psychological wellbeing. When her psychological needs were repeatedly frustrated, the nurse's narcissistic vulnerability triggered her cruelty. Stolorow, Brandchaft, & 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 common.

2 I have 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 my point of view of what I thought would be best for her. Could it be, by my offer of a practical solution to her life problems, which she doesn't want such as couples therapy for her and her husband I am trying to avoid having to hear and also experience with her the depths of her inner suffering and suicidal hopelessness?

3 Schwaber (1983, pp. 389390) 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 or she has been helpful and caring, but the patient's view is completely different. For example, Thomson (1994, pp. 128129) describes an episode where a patient's friend died from leukemia. Thomson believed he was compassionate upon hearing this upsetting news, but the patient strongly disagreed. Thomson reports that it was hard for him to decenter 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) goes on to discuss the need for therapists to work through and understand their "narcissistic sensitivities." The gain, from controlling narcissistic sensitivity, is a greater access to the patient's inner experience. Thomson (1994) says "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 pathway 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 accurate interpretation can sometimes be hurtful to a patient. Brandchaft & Stolorow (1994), describe an incident where a patient, Mr. J. came to a session very excited with a set of papers that chronicled insights he had discovered over the weekend about his early relationship with his father. The analyst, fascinated with the Mr. J's important insights, added some relevant explanations of his own. The session continued, but Mr. J., who had been enthusiastic and animated 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. 103122) describe several fascinating examples of therapeutic stalemates that are caused by a lack of reflective selfawareness on the part of the therapist. I will paraphrase one of their examples (see pp. 114121) as an illustration. 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. It turned out that what was most upsetting to Sarah was not necessarily the actual separation from the therapist, 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 was a person who, like Sarah, experienced a childself that had been responded to insufficiently. The therapist grew up "in a family that was pro-

foundly affected by the sudden death of his mother when he was eight years old" (p. 118). The therapist, in his own therapy, began to experience more fully his own vulnerable childself that had always been denied expression. As he began to change, his understanding of Sarah began to change 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 came to realize that his repeated reassurances that she could manage, felt to Sarah as "rejections of her childself" (p. 119). The therapist, by working through his own denial of the child in him, was able "to make empathic contact with the traumatized childself" (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 paper about clientcentered therapy. The answers to these questions will indicate the extent of the core compatibility of the clientcentered and self psychological approaches. Obviously giving unbiased and concise answers to these questions is not a simple and uncomplicated task.

1 Is clientcentered therapy a oneperson psychology, focusing primarily on the psychology of the client, as when reflecting a client's feelings, or is it a twoperson, 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 (Brodley, 1994). At the inception of clientcentered 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 clientcentered 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" (pp. 136). Thorne (1992, p. 88) also commented about the "nonrelational" 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 [19401944] 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 (Thorne, 1992, pp. 8384; Kirschenbaum, 1979, p. 277), (b) the dialogue with Martin Buber, in 1957, on "Ithou" interactions, which emphasized a "real reciprocity" in relationships (Thorne, 1992, pp. 6970, 8384), 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 and 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."

Brodley (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, 19771986, phase of his work than in the earlier, 19441964 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 Brodley (personal communication, July 23,

1995) disagrees that Rogers shifted from a oneperson to a twoperson psychology. She says:

I have been a clientcentered 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 twoperson psychology in the 1940s, it can be agreed that today, with its emphasis on humanness and congruence, clientcentered therapy is a relational, twoperson approach.

2 Is there sufficient interest, in the clientcentered approach, on how the subjectivity of the therapist influences the subjectivity of the client? For example, do clientcentered 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 or her own subjectivity in the therapeutic interaction. I have wondered whether clientcentered therapists reflect sufficiently on their own subjective experiences. For example, I haven't read in the clientcentered literature, as I have for self psychology (Stolorow & Atwood, 1992, pp. 103122), 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 shortterm therapy (C. R. Rogers, personal communication, August 23, 1983). For example, Rogers & Sanford (1984) said, "on the whole, the duration of clientcentered therapy is relatively short compared to that of a number of other therapies" (p. 1381). Was Rogers interested mainly in shortterm therapy because he was having more impact outside of the therapeutic field in the area of social action? Or was his interest in shortterm 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 clientcentered therapists have indicated that they do work longterm with clients (Raskin, 1986; B. T. Brodley, personal communication, August 12, 1995).

Tobin (1991) offered an interesting explanation of Rogers's interest in shortterm 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 selfreflective attitude of the clientcentered 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 clientcentered therapists. The focus of such meetings has to do with the therapist's direct reflections on their biases, histories, feelings, reactions that are interferring with their purity. This extreme focus on one's self as an influence is ... part of the essence of the meaning of congruence in clientcentered therapy.

From Brodley's comments, at least in theory, it does appear that a welltrained clientcentered therapist will reflect continuously on the involvement of his or her subjective experience in the therapeutic interaction.

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

A major strength of the clientcentered 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 clientcentered 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 clientcentered 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 clientcentered 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 apriori 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 clientcentered 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 nonsuspicious, noninterpretive, 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 clientcentered 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 heretofore not achieved degree of assertiveness, generosity, and affection. And it is in response to such a flawed parental self ... that the newly constitututed assertiveaffectionate self of the child disintegrates and that the breakup products of hostility and lust of the Oedipus complex make their appearance (p. 404).

Thus, Kohut, although he uses 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 or her experiences. Rogers, on the other hand, wanted to just be a companion to the client as the client discusses his or her life (Bohart, 1991, p. 41; Rogers, 1986a, pp. 207208). 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 t h e course of therapy.

It is to be noted that within the self psychology field there has been some disagreement on this issue; e.g., 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 clientcentered 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, & Brandchaft (1994b, p. xi) commented, a twoperson psychology allows for more flexibility so long as the therapist continually investigates the impact of his or her interventions on the patient's experiences.

Conclusions

With its emphasis on listening to the subjectivity of the client, without theoretical preconceptions, the clientcentered 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 selfrestraint 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. 195196).

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

Another important contribution, I believe, of the clientcentered approach is its democratic attitude. Carl Rogers espoused the ideals of compassion for people of all races, all economic groups, all nationalities, and both sexes. He encouraged people to give up narrow nationalistic interests in order to establish a more global community. The current limited therapeutic popularity of the clientcentered approach in the United States, where there are considerably more analytic training programs, may in part be due to the clientcentered values against elitism and materialism. It is interesting that the clientcentered approach is flourishing outside of the United States. The two major international clientcentered conferences, The International Conference on ClientCentred and Experiential Psychotherapy and PersonCentered Approach Forum are wellattended by people from all over the world. Illustrative of its desire to connect with people in remote areas of the world, the next PersonCentered Approach Forum will take place in South Africa in 1998. One extra benefit of the clientcentered or personcentered conferences, with their "community meetings" and "small group experiences," along with their more formal, intellectual presentations, is that they provide a relatively safe haven for participants to grow as persons. At self psychology conferences, where there is more of an emphasis on intellectual knowledge, such experiential interactions are rare. Rogers, when he was alive, used these large group "community meetings" to become more expressive, informal, and freer as a person (Kirschenbaum, 1979, pp. 333334).

The clientcentered approach also has broader, more general, and I might add, perhaps more ambitious goals than psychoanalytic self psychology. The domain of interest in self psychology is defined by its methods of investigation; that is, it is a scientific study of mental life using the tools of introspection and empathy. Clientcentered psychology, in addition to its interest in mental life and psychotherapy, is committed to broad social change. The clientcentered approach is not entirely a scientific enterprise; its primary goal is to foster a constructive "way of being." It is important to recall that clientcentered psychology is a part of humanistic psychology, whose aim was to enhance the lives of ordinary people, rather than to focus exclusively on therapy for maladjustment. Those who are clientcentered or personcentered are interested in more than just doing therapy. Personcentered people want to bring the philosophy of the actualizing tendency and the necessary and sufficient conditions to many aspects of life outside of therapy, 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 personcentered 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 clientcentered 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 "clientcentered therapy," "personcentered therapy." There is a pertinent quote by Irvin Yalom (1989) in his book "Love's Executioner" that fits perfectly with the Rogerian 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. Instead, we must speak of us and our 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 intune with Yalom's sentiments.

Final Remarks

After writing this paper, I have begun to think that at their core the clientcentered 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, etc. 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 clientcentered 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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