DIAGNÓSTICOS E ABORDAGEM CENTRADA NA PESSOA
DIAGNOSIS AND PERSON CENTERED APPROACH

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Abstract

It has been widely held that Carl Rogers was strongly negative towards diagnoses as useless and even harmful. However, during the analysis of his work, it appears that he used, without prejudice, the traditional diagnoses of psychopathology, as can be seen in works such as Psychotherapy and Personality Change (1954), Psychotherapy and its Impact (1967) and On Personal Power (1977). In our opinion, your attitude would be based on a pragmatic approach to communication. However, with the paradigm shift assumed in December 1940, from the biomedical to the "new therapies", C. Rogers started to use, without expressly mentioning it, a new diagnostic device. This "tool", based on the six necessary and sufficient conditions for therapeutic change, constitutes a relational "means of diagnosis" and, in our perspective, consistent with the attitude of trust in the client's capacity for self-organization, a fundamental element for the development of the therapeutic process. In this sense, the present article aims to describe C. Rogers' "journey" and his consistency of thought regarding the diagnostic process and its use.

Keywords: ACP; diagnoses; biomedical model; self-organizing model; therapeutic response.

Resumo

Tem sido largamente disseminada a ideia de que Carl Rogers possuía uma posição francamente negativa face à elaboração de diagnósticos, considerando-os inúteis e, mesmo, nocivos. Contudo, no decorrer da análise do seu trabalho, constata-se que utilizava, sem preconceitos, os diagnósticos tradicionais da psicopatologia, como é possível verificar em obras como *Psychotherapy and Personality Change* (1954), *Psychotherapy and its Impact* (1967) e *On Personal Power* (1977). Em nossa opinião, a sua atitude basear-se-ia numa abordagem pragmática da comunicação. No entanto, com a mudança de paradigma assumida em dezembro de 1940, do biomédico para o

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"das novas terapias", C. Rogers passou a utilizar, sem expressamente o mencionar, um novo aparelho diagnóstico. Esta "ferramenta", baseada nas seis condições necessárias e suficientes para a mudança terapêutica, constitui um "meio de diagnóstico" relacional e, na nossa perspetiva, coerente com a atitude de confiança na capacidade de auto-organização do cliente, elemento fundamental para o desenvolvimento do processo terapêutico. Neste sentido, o presente artigo tem como objetivo descrever o "percurso" de C. Rogers e a consistência do seu pensamento no que se refere ao processo de diagnóstico e sua utilização.

Palavras-chave: ACP; diagnósticos; modelo biomédico; modelo auto-organizativo; resposta terapêutica.

In the theoretical and clinical world of Client Centered Therapy / Person Centered Approach there seems to be a common "belief" that Rogers was deeply against the use of diagnoses in therapy. This belief is probably based on texts by the author such as: "I'm forced to the conclusion that such diagnostic knowledge is not essential to psychotherapy. .... a colossal waste of time" (Rogers, 1957, p. 95-103).

As mentioned in the Journal of Humanistic Psychology (1986c), Carl Rogers evolved and made his thinking more complex, in order to pass "from a young 'diagnostic-prescriptive' clinical psychologist to one who had come to trust the great potential residing within the individual for self-understanding and self-direction" (Rogers, 1990). This article presents a chronology of Rogers' perspective on the diagnostic process.

In Rogers first published book, *Measuring Personality Adjustment in Children Nine to Thirteen Years of Age* (1931/1972) he developed an instrument, referred yet nowadays (Burchinal et al., 1958; Westbury, 2011).

This book was followed on 1939 by *The Clinical Treatment of the Problem Child,* being the diagnostic quite present as a previous condition for treatment project, framing it on a quite traditional biomedical paradigm. In his next book, *Counseling and Psychotherapy* (1942), Rogers described the client's journey in five stages, one of which, the fourth, involves "positive planning and actions" suggesting a prior diagnosis. The path is described thus: (1) The client comes to help (2); He expresses emotionalized attitudes freely (3); This leads to the development of insights (4; These results in positive planning and actions (5) The client terminates the contact. Regarding "Insight", Rogers referred that, when the client develops insight into his personality, there is a reorganization of old facts that occurs (Rogers & Wallen, 1946, p. 53).

It should be noted that the biomedical paradigm is based on the diagnosis, which is expected to be etiological, allowing a successful specific treatment. Psychological diagnostic tools, like all other diagnostic tools used within the biomedical model, must more or less inevitably contribute to achieving this goal.

In the conference entitled Newer Concepts in Psychotherapy, held on December 11st, 1940 at the University of Minnesota, Rogers introduced a new paradigm, shifting from a biomedical model to the first approach to positive psychology embodied in a holistic approach centered on self-organization and self-reliance of the organism. In his speech, the following is mentioned: (1)

"(…) It relies much more heavily on the individual drive toward growth, health and adjustment; (2) "(…), places greater stress upon the emotional elements, than upon the intellectual aspects (…)"; (3) "(…) places greater stress upon the immediate situation than upon the individual's past"; 4 "(…) the therapeutic contact is itself a growth experience" (Rogers, 1942, 42-44)

Rogers was surprised by the reactions his speech provoked. He later regarded this conference as the birth of Client-Centered Therapy (Kirshenbaum, 2007, p. 109).

In his book entitled *Counselling and Psychotherapy* (1942), a basic hypothesis on Counselling was presented: "Effective counselling consists of a definitely structured permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation" (Rogers, 1942, p. 18). Posteriorly, Rogers presented the following provisional indication criteria for carrying out a therapeutic process: (1) The individual is under a degree of tension (…); (2) The individual has some capacity to cope with life. (…); (3) There is an opportunity for the individual to express his conflicting tensions in (…); (4) He is able to express these tensions and conflicts either verbally or (…); (5) He is reasonably independent, either emotionally or spatially, of close family control; (6) He is reasonably free from excessive instabilities, particularly of an organic nature; (7) He possesses adequate intelligence to cope with his life situation, (…); (8) He is of suitable age – old enough (…), young enough (…) roughly from ten to sixty. (1942, p. 76-77).

Rogers (1942) also mentioned the conditions of non-applicability of the Client-Centered Therapy model: "The component factors of the individual's adjustment situation are so adverse that (…); (2) The individual is inaccessible to counselling (…); (3) Effective environmental treatment is simpler and more efficient (…); (4) The individual is too young or too old, or too dull, or too instable (…)" (p. 78-79).

From a broader theoretical context, Rogers, in 1957, presented a "second diagnostic system", the Necessary and Sufficient Conditions of Therapeutic Personality Change - six conditions are postulated as necessary and sufficient conditions for the initiation of a process of constructive personality change:

> " (1) Two persons are in psychological contact; (2) The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious; (3) The second person, whom we shall term the therapist, is congruent or integrated in the relationship; (4) The therapist experiences unconditional positive regard for the client; (5) The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client; (6)The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved" (p. 95-103).

According to this new conception, "diagnostic knowledge is not essential for psychotherapy. However, in a footnote, Rogers (1957) states: "there is no intent here to maintain that diagnosis evaluations are useless. We have ourselves made heavy use of such methods in our research studies of change in personality. It is usefulness as a precondition to psychotherapy which is questioned" (Kirschenbaum & Henderson, 1990, p. 232).

Georges Engels (1977) also showed the insufficiency of this biomedical model and proposed "a new paradigm", not really a paradigm shift but an enrichment of the old model who become, the

"Bio psycho social" model. Later Engels' model got some "improvements" to become as including as *Bio psycho socio anthropological and noetic*. However, a deeper analysis of the model or of his utilization shows its strong main biomedical roots.

Some authors, as Lisbeth Sommerbeck, followed Rogers on the benefits of using psychopathology diagnosis, as a way of keep communication or understand other professionals (2003). As already mentioned, psychiatric diagnosis is not a problem in Client-Centred Therapy (...) However, both because of clients' questions about their diagnosis and because of the language of the medical model and psychiatric diagnosis which is dominant in the psychiatric hospital environment, the client-centred therapist must be able to communicate in this language with other staff and professionals when integrated in this professional culture. The therapist should thus be able to decode the perspective of the medical model but also from the client-centred perspective.

It should be noted that in the work Psychotherapy and Personality Change, Rogers mentioned "some of their clients' diagnosis: neurotics, borderline, normal (...)", "more acute schizophrenic, more chronic schizophrenics, normal and neurotics (...)" (Rogers & Dymond, 1954, pp. 41, 67).

In the book On Personal Power, Rogers also referred: "There is one perspective (...) which I, and most other humanistic psychologists, are reluctant to admit. This is the possibility that there was a chemical factor (...) His positive responses to a correct lithium dosage occurred twice – once in his depression and once when he was maniac – and forces me to consider this possibility" (Rogers, 1977/ 1986a, p. 232).

In fact, these quotations show that we are dealing with two different paradigms:

1. An essential biomedical, needing diagnostics to prescribe a treatment, even within psychodynamic orientated models, like the example of the "The Hamburg short psychotherapy comparison experiment" (Kimm et al., 1981; Meyer, 1981), where it was possible to find a well-structured study of brief psychoanalytic orientated psychotherapy using Malan's focus theory to support his therapeutic approach within a biomedical model. The study compares a sample of patients getting this treatment on a base of a biomedical diagnostic psychoanalytically orientated using Malan's brief focus theory to support his therapeutic approach, with another sample of patients getting time-limited therapy by Client-centered therapists, ignoring completely the psychoanalytical biomedical criteria for this treatment's choice, ignoring the basic psychoanalytical etiological hypotheses and using another therapeutic paradigm.

2. A holistic new paradigm offering to all the adequate clients the same therapeutic approach: Client-centered Therapy/Nondirective Therapy.

This new paradigm has, however, his own diagnostic system, which is based on the six necessary and sufficient conditions of therapeutic personality change proposed and discussed by Rogers: Either all the Six Conditions are present or not. If not, client-centered therapy it's not possible[3].

3 What can we do to make those missing available?
For example, Garry Prouty (1994) worked mainly with the first condition, but the same principles can be applied to all the remaining conditions. For Prouty (1994), "Pre-Therapy, in broad terms, is presented as the development of the psychological functions necessary for psychotherapy: reality, affective, and communicative contact.

In fact, several professionals recognize the importance of the six conditions. However, some of them claim that they are necessary but not sufficient; for others, they may be neither necessary nor sufficient, thus departing from Rogers' position.

The concept of the Person-Centered Approach appears as the philosophy behind all Carl Rogers interventions and the "core conditions" as

> growth promoting climate, whether we are speaking of the relationship between therapist and client, parent and child, leader and group, teacher and student, or administrator and staff. The conditions apply, in fact, to any situation in which the development of the person is a goal (Rogers, 1986b, p. 9).

The "core conditions" are congruence, unconditional positive regard, and empathic understanding. Later, Rogers added a fourth condition, presence (Brodley, 2011, p.140).

Barbara Brodley (2011) has demonstrated that Carl Rogers therapeutic practice and intervention remained quite stable and similar along all his life, no matters the evolution of his thinking, or as we would prefer, the unfolding of his reflections. She pretends that if Rogers' position on diagnostic and psychometrics usefulness changed within his lifespan, his practice remained constant.

Barbara Brodley studied 34 Rogers' interviews from 1940 to 1986. Although it was possible to find

> evidence of a radical shift from a theoretical to a functional nondirectivity and empathic understanding (…) between (circa) 1941 and (circa) 1945; there was possible to note that between 1944 and 1986 there is evidence of a development (…) towards a more personal expression of himself in his interaction with his clients (…). They are also, almost always, consistent with Rogers' theoretical and personal views that the only goals, when working with a client, are the goals for oneself – to be real, to be acceptant and to be empathic (2011, p.326).

In a personal communication, Brodley expressed her opinion that the stability in the Rogers practice along those 45 years, was constant together with his theoretical evolution.

Conclusion

In the new paradigm, the diagnostic system is based on the Six Necessary and Sufficient Conditions of Therapeutic Personality Change. According to our reflection and practice and following Rogers's proposal, we consider that these six necessary and sufficient conditions for therapeutic personality change can be used as a relational diagnostic system (Hipólito et al., 2014). This requirement points out the importance of other approaches when one of these conditions is not present, either to promote them or to find other applicable therapeutic proposals (Brites, et al., 2016).

Once the six conditions are present, it does not matter which psychiatric or psychological "label" or diagnosis was used, or which classification system was adopted, ICD-11 (World

Health Organization, 2022) or DSM-V (American Psychiatric Association, 2014). The indication for psychotherapy is present and the client can improve to become more and more a "fully functioning person" (Rogers, 1963, p.17).

Despite some psychiatrists may consider psychotherapy not indicated for certain psychiatric diagnoses, even considering the non-use of neuroleptics or the exclusive use of psychotherapy as a "bad practice", research shows that the client can find a positive evolution, either associating psychotherapy or community therapy.

Soteria's programs showed it, against medical opposition and preconceived ideas. We developed this approach in a 2007's paper, New Versions of Schizophrenia: psychotherapeutic advances (Hipólito, 2007).

As Sommerbeck (2003) mentioned, the psychiatric diagnostic might be useful, not only for research proposes, epidemical studies, or to share with other non-Client-centered clinicians, but to help to relief suffering in clients where the six condition are not present, or until they became present.

We can agree with Rogers (1951/ 2003) that: "…client-centered therapy has been at the end of the continuum in stating, as its point of view, that psychological diagnosis as usually understood is unnecessary for psychotherapy and may actually be a detriment to the therapeutic process". (p.220).

We can also agree with him in his statement:

> The therapist must lay aside his preoccupation with diagnosis and his diagnostic shrewdness, must discard his tendency to make professional evaluations, must cease his endeavors to formulate an accurate prognosis, must give up the temptation subtly to guide the individual, and must concentrate on one purpose only; that of providing deep understanding and acceptance of the attitudes consciously held at this moment by the client as he explores step by step into the dangerous areas which he has been denying to consciousness. Diagnostic knowledge and skill are not necessary for good therapy (Rogers, 1946, p. 421).

In the same way we have to coexist with Systemic and Cartesian paradigms, we will have to cope with the two paradigms in Therapy: the old Biomedical and the "New therapies "of Rogers' holistic Client Centered Therapy. In any case we should be aware of the need of being congruent in our therapeutic approach and most of all in every circumstance being congruent with this "new way of being", the Person-Centered Approach.

References

Brites, R., Nunes, O., Hipólito, J. (2016). Psychopathology and the Person Centred Perspective. In C. Lago & D. Charura (Eds), *The Person-Centred Counselling and Psychotherapy Handbook: Origins, Developments and Current Applications* (pp.91-101). Open University Press.

Brodley, B. (2011). *Practicing Client-Centered Therapy*. PCCS BOOKS.

Burchinal, L., Gardner, B., & Hawkes, G. (1958). A Suggested Revision of Norms for the Rogers Test of Personality Adjustment. *Child Development*, *29*(1), 135-139. https://doi.org/10.2307/1126277

Engels, G. (1977). The need for a new medical model: a challenge for biomedicine, science. *New Series*, *196*(4286), 129-136. https://doi.org/10.1126/science.847460

Hipólito, J. (2007). New versions of schizophrenia: psychotherapeutic advances. *Revista de Psiquiatria Consiliar e de Ligação*, *15*(1), 5-12.

Hipólito, J., Nunes, O., & Brites, R. (2014). Working with diagnosis and within psychiatric settings. About diagnosis: evolution and paradigm shift. In D. Charura & S. Paul (Eds), *The therapeutic relationship handbook: Theory and Practice* (pp. 196-205). Open University Press.

Kimm H. J., Bolz, W., & Meyer, A. E. (1981). The Hamburg short psychotherapy comparison experiment. The patient sample: overt and covert selection factors and prognostic predictions. *Psychotherapy and Psychosomatics*, *35*(2-3), 96-109. http://doi.org/10.1159/000287485

Kirshenbaum, H. (2007). *The Life and Work of Carl Rogers*. PCCS BOOKS.

Meyer, A. E. (Ed.). (1981). The Hamburg Short Psychotherapy Comparison Experiment. *Psychotherapy and Psychosomatics*, *35*(2-3), 77–212.

Prouty, G. (1994). *Theoretical Evolutions in Person-centered/Experiential Therapy: application to schizophrenic and retarded psychoses*. Praeger.

Rogers, C. (1942). *Counselling and Psychotherapy. Newer concepts in practice*. Houghton Mifflin.

Rogers, C. (1946). Significant aspects of client-centered therapy. *American Psychologist*, *1*, 415-422

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality changes. *Journal of Counselling Psychology*, *21*(2), 95-103. https://psycnet.apa.org/doi/10.1037/h0045357

Rogers, C. (1972). *Measuring Personality Adjustment in Children Nine to Thirteen Years of Age*. AMS Press (original work published in 1931).

Rogers, C. (1986a). *Carl Rogers On Personal Power*. Constable & Company (original work published in 1977).

Rogers, C. (1986b). Client-Centered Therapy. In I. Kutash & A. Wolf (Eds), *Psychotherapist's Casebook*. Jossey-Bass.

Rogers, C. (1986c) The Rust Workshop: A Personal Overview. *Journal of Humanistic Psychology*, *26*(3), 23-45. https://psycnet.apa.org/doi/10.1177/0022167886263003

Rogers, C. R. (1963). The concept of the fully functioning person. *Psychotherapy: Theory, Research & Practice*, *1*(1), 17–26. https://doi.org/10.1037/h0088567

Rogers, C. (1990). The Rust Workshop. In H. Kirschenbaum & L. Henderson (Eds), *The Carl Rogers Reader* (p. 465). Constable.

Rogers, C. (2003). *Client-Centered Therapy*. Constable & Robison. (original work published in 1951).

Rogers, C., & Dymond, R. (1954). *Psychotherapy and Personality Change*. University of Chicago Press.

Rogers, C., Gendlin, E., Kisler, D., & Truax, C. (1967). *The Psychotherapeutic Relationship and its Impact*. University of Wisconsin Press.

Rogers, C. & Wallen, J. (1946). *Counselling with Returned Servicemen*. McGraw-Hill Book Company.

Sommerbeck, L. (2003). *The Client-Centered Therapist in Psychiatric Contexts*. PCCS BOOKS.

Kirschenbaum, H & Henderson, L. V. (Eds.) (1990) *The Carl Rogers Reader*. Constable.

Westbury, H. (2011). *Young persons' constructions prior to and following parental brain injury*. University of Hertfordshire. PhD. Theses Collection.