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Carl Rogers and Schizophrenia. The evolution of Carl Rogers’ thinking on psychosis and schizophrenia: a literature survey

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ABSTRACT

In Carl Rogers’ written work schizophrenia and psychotic symptoms are mentioned over 2300 times. The use of the terms reflects the theoretical background prevailing at the time as well as the practical experience of Carl Rogers. Over the course of the publications a change in access to psychotic phenomena can be observed. In early years, Rogers viewed psychosis as fundamentally different from neurotic or ‘normal’ conditions. He emphasizes the inability of psychotherapy to treat psychosis. This perspective changes with the theoretical development of the person-centered approach. The concept of the dichotomy of neurosis and psychosis is rejected. Rogers is increasingly distancing himself from diagnostic labeling. He succeeds in presenting psychosis as an understandable process and thereby making it accessible to psychotherapy. The description of possible dangers in the therapeutic relationship are initially emphasized, but are losing importance in favor of a strong sense of confidence in the possibilities of the person-centered approach.

Carl Rogers et la schizophrénie. L’évolution de la pensée de Carl Rogers à propos de la psychose et de la schizophrénie. Une revue de la littérature.

Dans les travaux écrits par Carl Rogers, la schizophrénie et les symptômes psychotiques font l’objet de plus de 2.300 occurrences. L’utilisation de ces termes est le reflet du contexte théorique prévalent de l’époque ainsi que de l’expérience pratique de Carl Rogers. Au fil des publications, un changement dans la manière d’appréhender le phénomène psychotique peut être observé. Dans les premières années de sa pratique, Rogers considère la psychose comme fondamentalement différente des conditions névrotiques ou ‘normales’. Il souligne l’incapacité de la psychothérapie à traiter la psychose. Cette perspective change avec les développements théoriques de l’Approche centrée sur la personne. L’idée de dichotomie entre névrose et psychose est rejetée. Rogers se distancie de plus en plus de l’étiquetage diagnostique. Il arrive à présenter la psychose comme un processus compréhensible et de ce fait la rend accessible à la psychothérapie. Les dangers possibles décrits initialement pour la relation thérapeutique perdent de l’importance au

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Carl Rogers und Schizophrenie. Die Evolution von Carl Rogers’ Denken zu Psychose und Schizophrenie: eine Literatur-Studie


Carl Rogers y la esquizofrenia. La evolución del pensamiento de Carl Rogers sobre la psicosis y la esquizofrenia: una investigación basada en la literatura

Resumen: En el trabajo escrito de Carl Rogers, la esquizofrenia y los síntomas psicóticos se mencionan más de 2.300 veces. El uso de los términos refleja los antecedentes teóricos predominantes en ese momento, así como la experiencia práctica de Carl Rogers. A lo largo de las publicaciones se puede observar un cambio en el acceso a los fenómenos psicóticos. En los primeros años, Rogers veía la psicosis fundamentalmente diferente de las condiciones neuróticas o “normales”. Destaca la incapacidad de la psicoterapia para tratar la psicosis. Esta perspectiva cambia con el desarrollo teórico del enfoque centrado en la persona. Se rechaza el concepto de dicotomía entre neurosis y psicosis. Rogers se está distanciando cada vez más del etiquetar el diagnóstico. Logra presentar la psicosis como un proceso comprensible y así hacerla accesible a la psicoterapia. Inicialmente se enfatiza la descripción de posibles peligros en la relación terapéutica, pero están perdiendo importancia a favor de un fuerte sentido de confianza en las posibilidades del enfoque centrado en la persona.

Nos trabalhos escritos de Carl Rogers a esquizofrenia e os sintomas psicóticos são mencionados mais de 2.300 vezes. O uso desta
Psychotic symptoms in the writings of Carl Rogers

One of the great challenges in psychotherapy is dealing with people suffering from psychotic disorders. When one tries to orientate oneself according to the statements of Carl Rogers on the subject of psychosis, one will probably be confused at first by the different, sometimes contradictory statements on psychosis and schizophrenia. Here, an attempt will be made to structure Carl Rogers’ statements and to make the transformation of his view of psychosis and schizophrenia understandable.

Therefore all references to psychotic symptoms in Carl Rogers’ written works were sought out and the use of the psychotic descriptions in the written material was analyzed. In total, the words psychosis and psychotic appear over 900 times. Schizophrenia and schizophrenic are mentioned over 1400 times. It is not surprising to see a changing picture of the use of these terms over time. Although the themes of individual writings seem to be far ahead of their time and, on the other hand, older views are reused in texts published much later, the use of the terms is closely linked to the theoretical background and practical experience of Carl Rogers at the time.

This article will be limited to the examination of the existing literature written by Carl Rogers, and a note on the history of the concept of schizophrenia. More recent societal developments concerning e.g. the validity and reliability of the diagnosis of schizophrenia, as well as newer person centered treatment possibilities are not discussed.2

In order to present the changing subject areas over time, the present work not only considers the respective first publications, but also refers to later reprints edited or authorized by Rogers, that may reveal variations.

Brief outline of the history of the concept of psychosis

The term psychosis was first used by Carl Canstatt, who thus distinguished functional disorders of the ‘intelligent sphere of the nervous system’ from disorders of ‘other nerve
provinces’ (Canstatt, 1841, p. 328). Subsequently, the term psychosis is used very broadly for all mental disorders. Affective disorders such as depressive disorder and bipolar affective disorder are also called psychoses as well as schizophrenic disorders (cf. Hoenig, 1983). However, over the course of the following hundred years, the meaning of the term has been narrowed down.

**Dichotomy of neurosis and psychosis**

Through the work of Karl Jaspers, the dichotomy of psychosis and neurosis becomes the foundation of psychiatric nosology (Bürgy, 2008, p. 1202). Psychoses are considered as results of somatic illnesses and therefore regarded generally as (progressive) processes (Jaspers, 1913, pp. 265–268). On the other hand, neuroses are attributed to psychological biographical causes. They are regarded as development on a continuum with health. In contrast, it is stated that ‘psychoses are not comprehensible but only explainable’ (Bürgy, 2008, p. 1202). This leads to the view that psychotherapeutic approaches mainly deal with neurotic disorders that are considered comprehensible, whereas psychotic disorders appear to be neglected in the psychotherapeutic literature then.

**The untreatability of psychosis by psychotherapy**

The views of that time are also reflected in Carl Rogers’ writings. Influenced by the doctrine, in which psychoses, in contrast to neuroses, are not attributed to a psychological biographical cause and no transitions into health are seen, it is understandable that Rogers regards psychotic disorders as difficult to treat and as not sufficiently influenceable by client-centered counseling. ‘Counseling, from this viewpoint, cannot be the only method for dealing with that small group – the psychotic, the defective, and perhaps some others – who have not the capacity to solve their own difficulties, even with help’ (Rogers, 1942a, p. 128, 1989c, p. 87).

Deficits that appear fundamentally unalterable, such as the lack of ‘capacity to solve their own difficulties’, are attributed to those affected. ‘The individual is inaccessible to counseling, in that reasonable opportunity and effort fail to discover any means by which he can express his feelings and problems’ (Rogers, 1942c, pp. 78–79). The fundamental potential for development seems to be impossible for those who are affected, since the individual in the psychosis ‘cannot express his obviously conflicting attitudes’ (Rogers, 1942c, p. 79). This condition is regarded as so difficult, that psychotherapy is not seen as useful, but rather ‘justify focusing effort upon environmental measures rather than upon any sort of psychotherapy’ (Rogers, 1942c, p. 78). Rogers describes therapeutic environmental change – including forced measures against the will of the person affected – as necessary measures for people with psychotic disorders as well as for criminals, people with defect-syndromes, or for the ‘individual who is for other reasons incapable of taking responsibility for himself’ (Rogers, 1942b, p. 14). Psychosis is seen as a disorder in which the capabilities and potential of the person affected are severely limited. Here, the possibilities of psychotherapeutic treatment do not seem to exist.
The concept of dichotomy in the writings of Carl Rogers

Pessimism regarding the treatability of psychoses is based on the concept of an essential difference between psychotic disorders, which at the time were dichotomously differentiated from neurotic disorders. While neuroses demonstrate a smooth transition into health, psychoses are of a fundamental different nature. This view results in Rogers citing both neurosis and psychosis when talking about mental disorders due to the perspective of that time, which considered them as two completely different disorders. By explicitly mentioning both expressions (neurosis and psychosis), they are revealed as two very different entities that most definitely need to be mentioned separately.  

Careful wording

Noticeable is the choice of vague wording that Carl Rogers uses in his early work. He hardly writes about the full picture of psychosis, but prefers to use unobtrusive wording. For example, Rogers speaks of ‘very serious cases where the individual is on the brink of psychosis’ (Rogers, 1951a, p. 489). Here already the ‘brink of psychosis’ is described as very serious – not the full picture of psychosis. This careful wording probably reflects the fact that Carl Rogers could hardly gain any proper experience with people suffering from psychotic disorders during the early stages of his career. 

The lack of experience and therefore weak wording is also apparent in the following quotation in which Rogers describes the experiences of client-centered counselors in various fields and mentions (dichotomously) neurotic and psychotic disorders: ‘a wide range of neurotic problems, and to some extent with psychoses’ (Rogers, 1951b, p. 10). Here, too, the weakening limitation is shown by the wording ‘to some extent’ (see also Rogers, 1962b, p. 3; careful wording on schizophrenia can be found e.g. 1946, p. 417, 1964, p. 172, 1954c, p. 377, 1983, p. 176).

Psychosis as an expression of the severity of the disorder

The word psychosis seems to be used less as a technical term in publications of this time by Carl Rogers, but rather as an expression of a particularly severe disorder or a particularly dramatic development. In this sense, it is not surprising that psychosis occurs in the word combination with suicide – another dramatic situation, such as: ‘the individual is on the brink of psychosis or suicide’ (Rogers, 1951a, p. 489; see also, 1945, p. 21, 1961f, p. 107).

Dangers of psychosis

Psychosis however, is not only seen as a dramatically severe disorder, with seemingly undefeatable deficits to those affected, but also as something potentially dangerous and frightening. Thus, Rogers writes of the disturbing fear of the deeply suppressed violence, which a therapist senses in a psychotic client (Rogers, 1961a, p. 6). However, this is not the only risk. More often than the potential risk of an actual violent outbreak Rogers describes the risk that lies in the failure of distancing oneself from psychotic content or people.
Possibly, the focus on that risk is influenced by his own experiences in dealing with a client. In 1948/1949 Rogers had worked in an intensive therapy setting, in which he saw the client five times a week. According to his own statements, he felt threatened by the severity of the client’s psychotic disorder. Rogers was no longer able to distinguish between the client’s needs and his own (Groddeck, 2011, p. 98). He was not able to adequately differentiate himself (Groddeck, 2011, p. 99). In Howard Kirschenbaum’s biography, Rogers says ‘I got to the point where I could not separate my “self” from hers. I literally lost the boundaries of myself’ (Kirschenbaum, 1979, pp. 191–192, 2007, p. 184).

Although, Carl Rogers describes the loss of his boundaries, it is doubtful that there were really symptoms of a self-boundary or ego boundary disorder; rather, the dramatic words of his self-description are probably to be understood as an expression of his subjective feeling of threat. In an interview with David Russell, Rogers says that he was convinced that he was going psychotic, although no psychotic symptoms in the narrower sense can be deduced from the various descriptions of the incident (Rogers & Russell, 2002, p. 164). It is possible that the term psychotic is used as a metaphor to express the subjectively perceived dramatic severity of the problem. In another report about the same situation Rogers describes that he was on the edge of a complete breakdown (Rogers, 1967b, p. 367, 1972d, p. 57). It seems that psychosis is used in this context as a synonym for breakdown – a term that expresses the most severe psychic reaction, probably without claiming to be restricted by clear definitions.

**Vague diagnosis of schizophrenia**

Carl Rogers’ use of psychopathological terms, which largely omit clear definitions, can also be found in relation to schizophrenia. This may be due to the lack of clear diagnostic criteria for schizophrenia in the USA at that time.

An example of vague diagnostics is impressively demonstrated in the book ‘Critical Incidents in Psychotherapy’ in which case vignettes are commented on by experts including Carl Rogers (Standal & Corsini, 1959). Amongst others, the case of a 19-year-old female student is discussed. The school psychologist had diagnosed paranoid schizophrenia on the basis of a Rorschach test. From the circle of experts, only Viktor Frankl criticizes the lack of psychopathological evidence that would justify the diagnosis of schizophrenia. Frankl, who had a more differentiated diagnostic view through his studies and specialist training in Vienna, was able to evaluate schizophrenic symptoms better than his American colleagues, who thought that the diagnosis which is based on the projective test procedure is sufficient enough. It can also be assumed that Frankl was aware of Kurt Schneider’s ground breaking schizophrenia diagnostics (cf. Schneider, 1950), which had not yet been published in English at the time when the experts wrote the articles for Standal’s and Corsini’s book and was therefore not accessible to non-German-speaking experts (Schneider, 1959). This explains why psychotherapy was discussed here in the context of a schizophrenic disorder – although the person concerned probably did not suffer from schizophrenia at all.

A further example of unclear diagnosis of schizophrenia can be seen in the multi-annual program conducted by the University of Wisconsin in cooperation with the
Mendota State Hospital, which investigated the psychotherapeutic treatment of people diagnosed with schizophrenia (cf. Rogers et al., 1967). Eugene Gendlin’s annotation about the project illustrates, that the diagnosis of schizophrenia was often given very randomly. Gendlin stated that schizophrenia was considered ‘a label attached to anyone who is not clearly manic-depressive, alcoholic, epileptic, or something else one can define’ (Gendlin, 1966, p. 10). Schizophrenia was handled as ‘the catch-all category in hospitals’ without a clear psychopathological diagnosis.\(^{10}\)

**Schizophrenia as a synonym for psychosis**

One must consider the time of vaguely and randomly given diagnoses of schizophrenia, when viewing the use of the word *schizophrenia* by Carl Rogers. In his works *schizophrenia* does not appear as a clear defined diagnosis, but it replaces the term *psychosis* as a synonym in many ways. The fact that psychotic symptoms can exist even without the presence of schizophrenia spectrum disorders, such as severe depressive disorders, bipolar disorders, delusional disorders, etc. is not in Carl Rogers’ main focus.

If you compare, the passages about *schizophrenia* with the passages about *psychosis* in Rogers’ written work, clear parallels can be seen. Schizophrenia, like the word psychosis, is initially used as qualitatively different, dichotomous to neurosis (cf. Rogers, 1962b, p. 8).\(^{11}\) Carl Rogers hypothesizes that persons suffering from schizophrenic disorders, in contrast to other people, miss a ‘clearly differentiated, strong, internally organized self-configuration’ (Rogers, 1961a, p. 9).

Schizophrenia, like psychosis, appears as a term used to describe the severity of mental disorder. Schizophrenia, like psychosis, is described as a degree of disorder to which psychotherapy hardly has access to. Rogers points out that an individual with a schizophrenic disorder shows ‘inner disturbance’ which ‘makes it difficult for him accurately to perceive the conditions offered by the therapist’ (Rogers, 1962a, pp. 425–426, 1965b, p. 61) In a later version Rogers adds that ‘inner disturbance makes it difficult for him accurately to perceive the conditions offered by our conscientious and experienced [emphasis added] therapists’ (Rogers, 1967i, p. 100). With this addition, Rogers emphasizes that the inability to perceive the therapeutic conditions is not due to a lack of skill on behalf of the therapists, but rather due to the severity of the disorder.

**Relativization of diagnoses**

From a classical psychiatric point of view, the approach of using psychopathological terms and diagnoses without clearly defined boundaries seems unusual, however is probably understandable because Carl Rogers is increasingly turning against limiting and prescriptive diagnostics.

From the early 1950s Carl Rogers questions diagnostic attributions in his written works. Firstly, in a linguistically subtle manner, in which psychosis is not simply described as a fact, but is accompanied by relativizing additions. For example, Rogers no longer writes ‘neurotic or psychotic characteristics’ but ‘characteristics which are usually termed neurotic or psychotic’ (Rogers, 1954b, p. 5, 1961e, p. 36; cf., 1956a, p. 997). He does not speak of ‘psychotic behaviors’ but of ‘the behaviors customarily regarded as psychotic’ (Rogers, 1959a, p. 228) and of ‘so-called neurotic and psychotic behaviors’ (Rogers, 1960, p. 86).
Rogers speaks of diagnostic label (Rogers, 1967d, p. xvii; cf., 1967c, p. 1225) and of ‘behaviors which would be labeled as “psychotic” from a diagnostic frame of reference’ (Rogers, 1951c, p. 119).

Schizophrenia too – in the following quotation is again used as a synonym for psychotic – is provided with attributes that relativize the apparent facts of diagnoses and classifications: ‘so-called normal, neurotic, and schizophrenic persons’ (Rogers, 1961a, p. 19). Rogers formulates neatly, ‘It seems to say that human beings are persons, whether we label them schizophrenic or whatever’ (Rogers, 1962b, p. 15).12

Distancing from diagnostic constructs is also demonstrated clearly by quotation marks around the terms ‘normal’, ‘neurotic’ and ‘psychotic’ (e.g. Rogers, 1961h, p. vii). Rogers comments on the notation with quotation marks and explains, ‘the quotes indicate that for me these are all misleading labels’ (Rogers, 1961h, p. vii).

From 1974 Rogers usually combines quotation marks and a relativizing attribute and writes for example, of ‘usually termed “neurotic” or “psychotic”’ (Rogers, 1975a, p. 1842) and ‘categorized as “psychotic, “ neurotic,” or “normal”’ (Rogers, 1975a, p. 1833) – this, amongst others, also in his contribution to the ‘Comprehensive Textbook of Psychiatry’ (Freedman et al., 1975). It is probably no coincidence that Rogers chooses this stylistic device of double relativization by using quotation marks and the formulation ‘usually termed’ or ‘categorized as’ in the psychiatric textbook. This creates a distinct contrast to the clear attributions and diagnoses otherwise formulated in this book by other authors (see also Rogers & Wood, 1974, p. 214; Rogers, 1980b, p. 2153).

**Overcoming dichotomy**

Distancing from diagnostic constructs is accompanied by the proceeding development of concepts of psychotic and schizophrenic behavior.13 In the formal statement of the client-centered concept of 1959, the dichotomy of neurosis and psychosis that has been propagated since Jaspers and Freud is finally and explicitly rejected (Rogers, 1959a). Rogers writes about the client-centered concept: ‘It also avoids any concept of neurosis and psychosis as entities in themselves, which we believe has been an unfortunate and misleading conception’ (Rogers, 1959a, p. 228). Different forms of behavior are now seen along a continuum and Rogers’ concept ‘denies the conception of neurosis and psychosis as discrete entities’ (Holdstock & Rogers, 1977, p. 136). The difference between the psychotic or schizophrenic on the one hand and the normal or neurotic on the other is no longer seen as essentially fundamentally different. Rogers writes: ‘we have found the difference one of degree rather than kind’ (Rogers, 1962b, p. 12, 1967e, p. 188). About persons suffering from schizophrenic disorders Rogers writes:

We found them far more similar to, than different from, other clients with whom we have worked. They appeared to respond constructively, as do others, to subtle and freeing elements in an interpersonal relationship, when they were able to perceive these elements. (Rogers, 1967g, p. 93)
Theory formation

Rogers sees the gradual difference from normal to neurotic and mild psychotic to severe psychotic behavior as being due to a varying degree of incongruence of self and experience. If incongruence between self and experience existed and the experience was accurately symbolized in awareness, then there would be a risk that the self-concept might no longer be a consistent gestalt. (Rogers, 1959a, p. 227; see also, 1965a, p. 24). In the case of less severe psychotic symptoms – e.g. paranoid behaviors – defensive processes try to prevent the awareness of experience, data and intensionality, which are not consistent with the individual’s self-structure (Rogers, 1959a, p. 227).

This process consists of the selective perception or distortion of the experience and/or the denial to awareness of the experience or some portion thereof, thus keeping the total perception of the experience consistent with the individual’s self-structure, and consistent with his conditions of worth. (Rogers, 1959a, p. 227)

If there is a large or significant degree of incongruence between self and experience and if a significant experience occurs suddenly or very obviously ‘then the organism’s process of defense is unable to operate successfully’ (Rogers, 1959a, pp. 228–229). ‘In such a state of disorganization the organism behaves at times in ways which are openly consistent with experiences which have hitherto been distorted or denied to awareness’ (Rogers, 1959a, p. 229; cf., 1959d, p. 58). Thus, acute psychotic behaviors can be described as ‘consistent with the denied aspects of experience’ (Rogers, 1959a, p. 230). This would give rise to behaviors that appear to be irrational (cf. Holdstock & Rogers, 1977, p. 136).

Psychosis as an understandable process

These theoretical concepts form a contrast to the psychiatric point of view they had back then. In the tradition of Karl Jaspers, Kurt Schneider had postulated that psychotic experience and especially that of schizophrenic disorders is not comparable with ‘normal psychological’ thoughts, so that he means such experiences are not understandable (Schneider, 1950, p. 130). Carl Rogers, on the other hand, makes the process leading to the psychotic disorder and psychotic experience accessible to empathic understanding.

According to Rogers, the process begins with the person’s need to communicate and need to be understood. From this comes the impulse to express something which is a part of one’s private, inner world. If this message is not understood, a feeling of frustration and disappointment develops. If the hope of being understood by other people is lost, a withdrawal into an inner world follows. This can seem more bizarre to others through the loss of a reality shared with other human beings.

When I take the gamble, the risk, of trying to share something that is very personal with another individual and it is not received and not understood, this is a very deflating and a very lonely experience. I have come to believe that it is that experience which makes some individuals psychotic. They have given up hoping that anyone can understand them and once they have lost that hope then their own inner world, which becomes more and more bizarre, is the only place where they can live. They can no longer live in any shared human experience. (Rogers, 1969a, p. 227, 1980e, p. 14, 2014, p. 71)
With this explanatory model, Rogers puts the very understandable feeling of being misunderstood at the center of the process. In doing so, he goes against the assumption that psychoses are not understandable. Quite contrary to this assumption, he writes:

I can sympathize with them, because I know that when I try to share some feeling aspect of myself which is private, precious, and tentative, and when this communication is met by evaluation, or by reassurance, or by denial, by distortion of my meaning, I have very strongly the reaction, ‘Oh, what’s the use?’ I think at such a time one knows what it is to be alone. (Rogers, 1969a, p. 227, 1980e, p. 14, 2014, p. 71)14

Hence, psychosis becomes something more comprehensible and understandable which in some way ties in to everyday experiences. This enables Carl Rogers to take the step from psychoses, which were considered ‘not comprehensible but only explainable’, to understandable psychic phenomena, which are accessible through empathy. From an understanding attitude, Rogers notes, for example, with regard to the psychotic symptom of hallucination, for the behaviors described as psychotic: ‘When one sees these behaviors from the internal frame of reference their functional meaning appears so clear that it becomes incomprehensible that they should be regarded as symptoms of a “disease”’ (Rogers, 1951c, p. 119).

The problem of loneliness

Rogers does not deny any medical factors that can promote the occurrence of psychosis, but in his opinion the cause of psychosis lies in the breakdown of human relationships (Rogers, 1959c, p. 74). Rogers no longer sees the individual as sick and disturbed. In his opinion, the main problem lies in relationship aspects. The isolation, which results through the failure of relationships, is both terrible and disorganizing (Rogers, 1959c, p. 74).

The therapeutic task is to have a real relationship with the person who is lonely. Neither diagnosing, analyzing nor perceiving impersonally are helpful. Rogers sees the therapeutic path in the relationship:

We are deeply helpful only when we relate as persons, when we risk ourselves as persons in the relationship, when we experience the other as a person in his own right. Only then is there a meeting at a depth that dissolves the pain of aloneness in both client and therapist. (Rogers, 1980c, p. 179, 1989a, p. 168)

The dangers in the therapeutic relationship

During those years, when Rogers hardly gained any experience treating people suffering from psychotic disorders, his works were written more pessimistically, regarding this subject area. Rogers saw people with psychotic disorders who ‘lose contact with reality’ and therefore are ‘often unable to take counseling help’ (Rogers, 1942c, p. 80). As his personal experience in psychotherapy with people suffering from psychotic disorders increased, these pessimistic statements slowly started to fade. Psychotherapy seems possible. A psychotherapeutic approach is increasingly being addressed. Nevertheless, Rogers thinks that psychotherapy with people suffering from psychotic disorders involves great risks and courage is required:
If you really understand another person in this way, if you are willing to enter his private world and see the way life appears to him, without any attempt to make evaluative judgments, you run the risk of being changed yourself. You might see it his way; you might find yourself influenced in your attitudes or your personality. (Rogers, 1959b, pp. 234–235, 1961b, p. 411, 1961d, p. 333, 1967a, p. 472; Rogers & Roethlisberger, 1956, p. 154, 1990, p. 21)

Maybe the influence of his own experiences with the lack of boundaries – in the unfortunate contact with the client suffering from a psychotic disorder in the late 1940s – Rogers states: ‘This risk of being changed is one of the most frightening prospects many of us can face’ (Rogers, Rogers, 1961b, p. 411; cf., 1967a, p. 472; Rogers & Roethlisberger, 1956, p. 154, 1990, p. 21). Also based on his own experience, Rogers recommends that ‘the therapist must be safe, must be a thoroughly separated person who perceives himself as a different person from his client, so that he does not become entangled in the strong feelings of his client and be overwhelmed by them’ (Rogers, 1961a, pp. 6–7). Rogers includes himself when he emphasizes that ‘many of us, I am sure, have learned this at considerable cost to ourselves’ (Rogers, 1961a, p. 7).

The importance of congruence

Rogers stresses the importance of the therapist’s independence and transparency. Especially in psychotherapy with people suffering from schizophrenic disorders, Rogers emphasizes the importance of congruence, which he has ‘gradually come to believe that this is the most basic condition of all psychotherapy’ (Rogers, 1961a, p. 6).\(^\text{15}\) He refers to Eugene Brody, who ‘pointed out the sensitivity of the schizophrenic to the unverbalized or partially conscious feelings of the therapist’ (Rogers, 1958, as cited in Shlien, 1961, p. 304; cf. Brody, 1952). Rogers believes ‘to be transparent to the client, to have nothing of one’s experience in the relationship which is hidden’ is basic to effective psychotherapy (Rogers, 1961a, p. 6). Carl Rogers writes that

> the therapist, by being openly and freely himself, is ready for and is offering the possibility of an existential encounter between two real persons. The schizophrenic, to be sure, can only rarely and fleetingly and fearfully avail himself of such an encounter, but it is these moments, I believe, which are therapeutic. (Rogers, 1958, as cited in Shlien, 1961, p. 304; Rogers, 1961a, p. 6)

General therapeutic principles

As the dichotomy of neurosis and psychosis dissolves and psychosis is understood as a comprehensible occurrence which is not fundamentally different from ‘normal’ behavior, Rogers increasingly emphasizes that those therapeutic conditions which lead to constructive personality development also apply to psychotic and schizophrenic disorders. At first, Rogers formulates this as a hypothesis (Rogers, 1961a, p. 5), and subsequently as a clear statement (Rogers & Wood, 1974, p. 233; Rogers, 1975a, p. 1833, 1980b, p. 2155), even though Rogers often takes the sharpness out of his statements by combining conceptual expressions with stylistic devices such as ‘I feel’ (see Buber et al., 1997, p. 52).\(^\text{16}\)
Dealing with psychotic content

In the theoretical explanatory model Rogers writes of ‘denied aspects of experience’, which can be in accordance with acute psychotic behavior (Rogers, 1959a, p. 230) – in the therapeutic relationship, however, he considers psychotic material as less essential. He writes, ‘we have learned how relatively unimportant is psychotic material’ (Rogers, 1962b, p. 12, 1967e, p. 188). In the psychic dynamics of schizophrenia, the psychotic symptoms have their meaning, but ‘in the therapeutic relationship it simply forms a more difficult language of communication' (Rogers, 1962b, p. 12, 1967e, p. 188). Psychotic symptoms ‘represent a mode of communicating (…) which is often very difficult to understand’ (Rogers, 1962b, p. 12, 1967e, p. 188). It is not the analysis of psychotic content that is beneficial in therapy, but relationship aspects that are effective even without understanding the psychotic symptoms. Although accurate, empathic understanding would be by far the most helpful – if this is not possible, ‘even the intent to understand can itself be of value’ (Rogers & Wood, 1974, p. 233; cf. Rogers, 1975a, p. 1833, 1980b, p. 2155).

Especially for people with psychotic disorders the experience of someone trying to understand these ‘bizarre, confused, uncertain statements’ is important. This encourages the person affected to communicate more about himself or herself. The experience of someone trying to understand those psychotic manifestations supports ‘to recognize that the therapist perceives his feelings and meanings as worth understanding, and that he [the person affected], therefore, is worthwhile’ (Rogers, 1975a, p. 1833; cf. Rogers & Wood, 1974, p. 233; Rogers, 1980b, p. 2155).

In this way, beneficial processes can occur in therapeutic contact – even if the therapist cannot understand the content of the psychotic expressions. To experience the effort of the therapist and the attention that the person’s feelings and statements receive – and thereby the attention that the person receives – are effective.

Establishing relationships

By emphasizing relationship aspects for therapy and considering psychotic material merely as a ‘difficult language of communication’ (Rogers, 1962b, p. 12, 1967e, p. 188), it is possible to see psychotherapy with people with psychotic disorders under exactly the same conditions as therapeutic contact outside a psychotic context. So, it is not surprising that Rogers also emphasizes in conversation with Martin Buber that ‘that there is no difference in the relationship that I form with a normal person’ or to a person suffering from schizophrenia or paranoia (Buber & Rogers, 1960/1999, p. 257; Friedman, 1965, pp. 174–175; Buber et al., 1997, p. 52). In conversation with Buber, he stresses ‘I don’t really feel any difference’.

Spectrum of the effective range

In earlier years, Rogers had used the word combination of neurosis and psychosis (occasionally schizophrenia as a synonym) mainly to describe the spectrum of mental disorders, whereby the explicit mention of both terms had pointed out the essential difference between the disorders. After the theoretically justified distancing from the dichotomous
difference of the disorders and the observation that the same conditions for constructive personality development apply to ‘normal’ individuals as well as to people with psychotic or schizophrenic disorders, Rogers’ written work changes the use of neurosis and psychosis. Now the stylistic device is used to refer to both terms in order to describe, together with the term ‘normal’, the entire spectrum of the human psyche.\textsuperscript{18}

The words psychosis and schizophrenia seem to be used mainly by Rogers to denote the end of the spectrum opposite to healthy.\textsuperscript{19} Rogers uses the terms to frame any mental state by spanning the spectrum from ‘normal’ to severely affected (cf. e.g. Rogers, 1956b, p. 199).\textsuperscript{20} He uses the stylistic device of citing psychosis or schizophrenia as an opposite pole to normal behavior in order to open up the sphere of action in which person-centered relationship formation is beneficial. This stylistic device is mainly used to show the general validity of the person-centered hypotheses. Whether it is a ‘healthy’ person or a person with neurotic, psychotic or schizophrenic disorder, relationship in a person-centered attitude is beneficial.

**Confidence**

In later years, Rogers’ written work, no longer places the emphasis on the different nature of psychosis or the danger in dealing with it, but rather on confidence in the ability to develop – which is now also conceded to people with psychotic disorders. Earlier writings already emphasized the belief in the power of relationship and the ability to develop, but in the later years of his written work these statements are found unclouded by an emphasis on the essential different nature of psychosis or by fears of dealing with people suffering from the symptoms of schizophrenia.

Now trust can develop in the forward-moving tendency of the human organism, to which Rogers had already referred to in earlier writings. He writes about that tendency on which therapists can fundamentally rely:

> It is evident not only in the general tendency of clients to move in the direction of growth when the factors in the situation are clear, but is most dramatically shown in very serious cases where the individual is on the brink of psychosis or suicide. Here the therapist is very keenly aware that the only force upon which he can basically rely is the organic tendency toward ongoing growth and enhancement. (Rogers, 1951a, pp. 489–490)

Confidence in the forward-moving tendency, enables relationship without fears. Thus, as described by Carl Rogers on dealing with ‘very troubled and psychotic individuals’: ‘If one is able to get to the core of the person, one finds a trustworthy, positive center’ (Rogers, 1987, p. 180, 2002, p. 61) – regardless of whether the person has been labeled as psychotic or schizophrenic.

**Notes**

1. The words psychosis, psychotic, schizophrenia, schizophrenic, hallucination, hallucinate, paranoia, paranoid were reviewed. Those references that are merely descriptive of clients have been eliminated.
2. To learn more about concepts of person-centered psychotherapy with people suffering from psychotic disorders see e.g.: (Crisp, 2019; Dekeyser et al., 2008; Mearns et al., 2006; Miksch, 2000; Oberreiter, 2018c, 2020; Prouty, 1983, 1991, 1994, 2002; Prouty & Kubiak, 1988a, 1988b;


6. ‘I see now that I handled her badly, vacillating between being warm and real with her, and then being more “professional” and aloof when the depth of her psychotic disturbance threatened me’ (Rogers & Russell, 2002, p. 164).

7. For diagnostics of ego boundary disorder see (Oberreiter, 2018b, 2019, 2020).

8. ‘I really became quite convinced that I was going psychotic, and probably I was’ (Rogers & Russell, 2002, p. 164).

9. ‘I realized I was on the edge of a complete breakdown myself’ (Rogers, 1967b, p. 367, 1972d, p. 57).

10. Frankel & Sommerbeck point out that Rogers’ theory of therapy changed radically in the course of the Wisconsin project. They see the reasons for this change in Rogers’ thinking in the therapists’ difficulties with the client-population of the Wisconsin research (Frankel & Sommerbeck, 2005).

11. ‘the great qualitative differences we have found between our schizophrenic clients, and the clinic clients with whom we had previously worked’ (Rogers, 1962b, p. 8, 1967e, p. 184).

12. In the later published version, distancing from labelling seems to be reinforced by an accentuation of the time form: ‘It seems to say that human beings are persons, whether we have labelled them as schizophrenic or whatever’ (Rogers, Rogers, 1967e, pp. 191–192).


14. alone is in italics only in Rogers, 1969a, (p. 227).


16. E.g. ‘It may be somewhat of an aside – but one on which I feel very strongly – to point out that “mental breakdown,” “mental illness,” “schizophrenia,” and the like are, except in very special cases, not diseases’ (Rogers, 1972c, p. 197). Or e.g. ‘I feel there is little doubt but that heredity, constitutional makeup, and chemical factors all have a part in the predisposition to psychosis. I feel, however, that psychologically a psychosis occurs when human relationships break down’ (Rogers, 1959c, p. 74).


19. ‘Having completed our work with schizophrenics, I have been eager to turn to working with “normal” individuals – the other end of the spectrum’ (Rogers, 1967b, p. 374, 1972d, p. 65).

20. ‘a wide range of personality disturbances, from the normal person to the frankly psychotic’ (Rogers, 1956b, p. 199).
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