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*The Official Journal of the Association for the Development of the Person-Centered Approach*

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Editors’ Introductory Commentary

We want to highlight the upcoming Annual Conference of the Association for the Development of the Person-Centered Approach (ADPCA). It will be held on the campus of Kutztown University in Kutztown, Pennsylvania from July 24-28, 2019. See the ADPCA website for registration information. A brochure will be mailed to the ADPCA members.

The first issue within this double issue of the Person-Centered Journal (PCJ) provides readers with three different articles. The article by Jerome Wilczynski, “Commonalities Between Client-Centered Therapy and How God’s Grace Works: Finding a Path Toward Client-Centered Christian Spiritual Counseling,” delineates the similarities between how the change process is conceived in client-centered theory and therapy and how God’s grace works, as well as how transformative change happens from a spiritual perspective. Given these similarities, the author contends that Christian spiritual counseling should proceed in the same manner as client-centered therapy. Doing so allows the relationship between counselor and client to mirror the divine–human relationship.

The article by Susan Pildes and Kathryn Moon, “‘I Didn’t Know You Felt That Way”: The Practice of Client-Centered Couple and Family Therapy,” describes how the authors work when seeing couples and families in therapy. While the non-directive attitude guides their interaction, just as it does when they work with individuals, the way they express empathic understanding changes. When working with couples and families, the authors are more explicit with providing their thought process when relating their empathic understanding; this is done to lessen the possibility of misunderstandings. The authors contend the possibility for misunderstanding increases among those present when there is more than one client in the consulting room.

The last article in this issue, “Real Human Connection: There is no app for that!,” is by David Myers and Jessica Miller. They explore the paradoxical problem of how college students are less personally engaged with others even though they live in a “connected” world.
vis-à-vis a myriad of social media outlets today. The authors explore how college personnel from instructors, to resident-hall advisors and administrators may adapt client-centered theoretical principles outside the counseling situation to assist students in feeling connected.
Commonalities Between Client-Centered Therapy and How God's Grace Works: Finding a Path to Client-Centered Christian Spiritual Counseling

Jerome Wilczynski
Argosy University, Chicago

Abstract
There are striking similarities between the way Carl Rogers (1957, 1959, 1961) conceived of the counselor-provided conditions in client-centered therapy leading to client change, and how Christian theological writers such as Edward Schillebeeckx (1968/2005, 1979, 1980, 1987, 1991) and spiritual writers like Anthony DeMello (1990) describe the divine–human relationship and how this leads to change for human beings. Given these similarities, the author posits that Christian spiritual counseling should proceed in the same manner as client-centered therapy. Doing so allows the spiritual counseling relationship to mirror the God–human relationship as it empowers personal and spiritual growth for humanity.

Introduction
This article explores the commonalities between how client-centered (CC) therapy achieves its purpose of being a constructive therapeutic relationship for client change (Rogers, 1957, 1959, 1961) and how God’s grace works from a Christian theological viewpoint (Schillebeeckx, 1980, 1991). To do this, one must appreciate how a specific understanding of God and God’s way of relating to creation is

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Author’s Note: You will notice that I deviate from traditional citation process when I cite books by including page numbers when I am paraphrasing. Providing the page numbers facilitates the reader’s ability to find this information within these voluminous texts. Special thanks to Alex DeMarco who provided invaluable copy/theological editing.
conceived (Schillebeeckx, 1968/2005, 1979, 1980, 1987, 1991), as well as how spiritual change can be posited (DeMello, 1990). Once this is elucidated, the striking similarities between how change is achieved in CC therapy and how God’s grace works leads to the conclusion that Christian spiritual counseling should be conducted in the same fashion as CC therapy. Doing so allows the Christian spiritual counseling relationship to mirror the relationship between God and human beings.

**Pertinent Concepts from Client-Centered Theory and Therapy**

In Carl Rogers’ (1959) CC theory, there is a sole drive that propels all life processes; he referred to this as the *actualizing tendency*. The actualizing tendency is defined as “the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism” (Rogers, 1959, p. 196). This finds expression in two main ways within a human being: The individual’s sense of their bodily or organismic experience and the way they view themselves psychologically, referred to as the self-system (Rogers, 1959). “If the self and the total experience of the organism are relatively congruent, then the actualizing tendency remains relatively unified. If self and experience are incongruent, then the general tendency to actualize the organism may work at cross purposes with the … tendency to actualize the self” (Rogers, 1959, pp. 196–197). Rogers (1959) states such incongruences within the person can lead to psychological maladjustment. While incongruences result from denied or distorted experiences, they can also arise from adopting or internalizing the expectations of others that are “at odds” with the experience of an individual. When this happens, maladjustment is said to be caused by internalizing the “conditions of worth” that others hold for a person (Rogers, 1959).

When a client experiencing incongruence (i.e., maladjustment) comes to a CC therapist for help, the counselor provides conditions within the relationship which Rogers (1957) asserts to have a therapeutic effect. These conditions entail the counselor’s being congruent, that is they must be accurately aware of their experience in the relationship with the client (Rogers, 1957). The counselor strives to experience *unconditional positive regard* for their client; meaning, they seek to accept “each aspect of the client’s experience as being a
part of that client … [This] means that there are no conditions of acceptance, no feeling of ‘I like you only if you are thus and so’” (Rogers, 1957, p. 98). And, the counselor seeks to experience “an accurate, empathic understanding of the client’s awareness of [their] … experience [or internal frame of reference]” (Rogers, 1957, p. 99). This means a therapist strives to “sense the client’s private world as if it were [the therapist’s] own” (Rogers, 1957, p. 99). If the counselor is able to provide these conditions, a “process of constructive personality change will follow” (Rogers, 1957, p. 96). This occurs because the unconditional environment provided by a CC therapist counteracts the conditional aspects of a client’s experience, thereby allowing them to accurately perceive and correct incongruences within the totality of their lived experience (Rogers, 1959).

### Edward Schillebeeckx’s View of God and God’s Relation to Creation

Roman Catholic priest and theologian Edward Schillebeeckx’s (1914–2009) conception of God is rooted in human experience. For Christians, Judeo–Christian history is the source material for understanding God. In the history of the Jewish people, moments of liberation have been interpreted as being supported by God. Christians interpret the liberation that comes from the way of life espoused by Jesus of Nazareth as being rooted in God’s desire for people to be freed from all the forces that oppress them (Schillebeeckx, 1991, pp. 8–10, 121–123). It is precisely in this way that we encounter God. Our experience of God is always mediated through historical, worldly events as well as inner human experiences (Schillebeeckx, 1980, pp. 809–817; Schillebeeckx, 1991, p. 70).

Precisely because we have no unmediated experience of God, Schillebeeckx states we are forced to acknowledge something about God. Namely, God cannot be apprehended with any specificity, and therefore God is beyond all created reality. Yet, at the same time, we experience God as somehow present within us. This double experience allows Schillebeeckx to state that God transcends all reality and is simultaneously immanent or present within all that exists. In fact, we can only relate to God because of God’s immanent presence within us; the aspects of God’s existence that transcend created reality are beyond our relational grasp (Schillebeeckx, 1979, p. 627;
Schillebeeckx, 1991, pp. 57, 74–77). Because our God experience involves interpretations of both our inner experience and historical events (Schillebeeckx, 1980, p. 809, 1991, p. 70), Schillebeeckx (1968/2005) is able to say that God interpenetrates all created reality (pp. 127–129). He therefore concludes that God transcends as well as interpenetrates all creation, while remaining intimately available to us inwardly and through worldly events vis-à-vis faith-based interpretations of experience (Schillebeeckx, 1968/2005, pp. 127–129; Schillebeeckx, 1979, p. 627).

Schillebeeckx (1991) is aware that defining God from human experience is potentially fraught with problems, for in doing so we are using human characteristics to describe something that is totally other than human; but we simply have no other means for describing God (pp. 57, 74–77). A perfect example of this difficult state of affairs is how human beings may only liberate others from oppression by “doing things” to help them (p. 231); but God works differently. God liberates from within the person by empowering them to actualize their freedom (p. 90). Christians interpret the freedom they experience to effectuate their lives for happiness as coming from God. This inner freedom allows one to be outwardly free to care for others, which is the defining hallmark of the way of life espoused by Jesus of Nazareth. In the New Testament, we see these characteristics of God—willing freedom and liberation—exemplified in the life of Jesus. This is why Christians understand Jesus to be the human revelation of the invisible God (Schillebeeckx, 1991, pp. 7, 31–32, 90, 121–123).

Whereas human beings may fail to choose the good when confronted with a choice between good and evil, we know from the always compassionately lived life of Jesus—where he consistently championed the good and sought to heal every evil afflicting those he encountered—that God only acts for good, never for evil (Schillebeeckx, 1980, pp. 725–730; Schillebeeckx, 1991, pp. 121–122). Observing this about Jesus, Schillebeeckx says that God has no encumbrances (i.e., possesses absolute freedom) to effectuate the divine nature as unconditional love and pure positivity. In other words, God does not make decisions between good and evil; God freely and absolutely exercises the positivity of the divine nature without any temptation toward evil whatsoever (Schillebeeckx, 1980, p. 727; Schillebeeckx, 1987, pp. 104–105).
Schillebeeckx (1991) also states that we can use observation of the world around us to say something about how God relates to creation. We can assuredly say God respects the freedom of creation, because we notice “in nature there is chance and determinism; in the world of human activity there is the possibility of free choices” (Schillebeeckx, 1991, p. 91). If this were not so, “we and our history would be merely a puppet show in which God holds the strings” (Schillebeeckx, 1991, p. 91). If God can be said to respect the freedom of creation, what can we say about God’s activity within it?

From an examination of the world around us, we see that God does not directly intervene within the world or our lives (Schillebeeckx, 1979, p. 627). Instead, Schillebeeckx (1991) asserts, “the action of God in world history is … always the divine activation of worldly, historical and human powers and possibilities” (p. 83); this is called God’s grace. Grace empowers the natural processes of life, but it does so without controlling them. In other words, God’s grace operates in worldly and human actions (Schillebeeckx, 1980, pp. 810–817); it cannot be identified as something separate from naturally occurring phenomena (Schillebeeckx, 1991, p. 234). Given this, are we to also conceive of God as being at work in all worldly and human actions and/or decisions?

No. God’s grace only empowers worldly and human actions/decisions which bring forth the good in life (Schillebeeckx, 1980, pp. 791, 808–814); grace does not empower destructive life processes (pp. 726–730). Therefore, we can always count on God’s immanent presence within us to faithfully act in all our choices and actions for the good (p. 808), never in our harmful actions or decisions (Schillebeeckx, 1980, p. 791).

**Anthony DeMello’s Insights:**

**How People Change from a Spiritual Perspective**

Roman Catholic priest and psychotherapist Anthony DeMello (1931–1987) wrote a very insightful book on spiritual change. In this book, DeMello (1990) advises us to simply observe ourselves (p. 56). Through observation, you begin to understand yourself; you do not need to do anything beyond this (p. 90). DeMello says that when you try to change you run head-on into the problem of your attachments. You want something for yourself and you become “attached” to that...
desire (pp. 137–140). The more you pursue that desire for change, the more you “rail against” something in your life; and the more you do that, the more power the situation gains over you. DeMello advises that we stop fighting whatever we want to change. Instead, we should simply understand it (DeMello, 1990, p. 147). But how does one do that?

We accomplish this by being aware of what is happening in our lives. When we do not push ourselves to change, but simply pay attention or give awareness to ourselves, change becomes possible (DeMello, 1990, pp. 166–168). There is no technique one can teach for doing this (pp. 35–37), but DeMello does offer some basic assistance: Pay attention to your environment, what you are thinking or feeling. Do not try to change whatever you are thinking or feeling—just notice those things (pp. 45–46). You will begin to gain insights about what is going on, i.e., how you are attached to something and how attachments cause suffering (pp. 46–50). Once you are aware of what is going on in your life, change happens naturally without you attempting to make it happen. The more you try to change, the more arduous and unsuccessful the process will be (DeMello, 1990, pp. 166–168).

Bringing Schillebeeckx and DeMello Together on Change Process

The foundation has been laid for us to unite the theological and spiritual with counseling. But before we can do that, we must bring together some of the ideas of Schillebeeckx and DeMello. In particular, we must address why we human beings may experience God’s grace as “challenging” us in the spiritual change process, and why we likely have such experiences.

Schillebeeckx (1991) states that human beings may experience God’s grace as challenging them (p. 90) to live in life-enhancing ways (Schillebeeckx, 1980, p. 791). To understand how this experience comes about within us, we must recall DeMello’s (1990) insights on how spiritual change happens. When we pay attention or are aware of what is going on within us, insights come; we begin to see things for what they are within our lives and we begin to see what causes our suffering (DeMello, 1990, pp. 45–50). Even though such revelatory processes are a product of our inner experience, we can certainly state
this “challenging” awareness involves God’s grace if, as Schillebeeckx (1980) contends, the process is life-enhancing (p. 791).

Although Schillebeeckx never explicitly reveals how the inner process of spiritual change happens, his writings seem to affirm DeMello’s (1990) understanding that this happens within a situation of unconditionality (pp. 45–50, 166–168). For example, Schillebeeckx (1991) states God is not invested in our choosing one path over another as we seek to overcome all that hampers our lives (pp. 230–231); God simply wants us to thrive and flourish (Schillebeeckx, 1987, pp. 104–105). Even though the divine has no pre-determined plan for how that should happen (Schillebeeckx, 1991, p. 91), engaging with God in prayer somehow allows us to see the things that need to change in our lives (Schillebeeckx, 1980, p. 817).

This must come about because, as Schillebeeckx (1987) indicates, God’s love for us is unconditional (p. 104). If it is unconditional, the person should not experience God as controlling or directing their inner process. In fact, this is precisely how we saw Schillebeeckx depict the relationship between God and human beings in the preceding paragraph; and, this coheres with Schillebeeckx’s (1980) assertions that God’s grace does not control life processes (pp. 810–817). Even so, Schillebeeckx (1991) does leave the “door open” for God to spontaneously urge humanity toward the good in life, yet always allowing for us to refuse the invitation (pp. 90–91). Thus, we may say that the interactive process between God and human beings happens without divine manipulation (p. 91), for even when God spontaneously prompts us toward the good, we are free to refuse. The divine certainly respects our freedom (Schillebeeckx, 1991, pp. 90–91).

Therefore, if we bring together Schillebeeckx’s views on God’s way of relating to us and DeMello’s understanding of how we change, the process of spiritual change that is revealed is paradoxical: God not controlling or directing our inner process is exactly what allows us to change! Engaging with God’s unconditional love allows us to become aware of the issues that need changing in our lives. Whether the “challenge” we experience comes from our awareness process as we deliberately engage with God, or whether we interpret the experience as coming from the divine spontaneously makes no difference. For God’s grace can be said to be involved, as Schillebeeckx (1980) states, in all processes that are life-enhancing (p. 791).
How Does This Apply to Christian Spiritual Counseling?

All of what has been stated above regarding God and God’s relation to creation as well as to change in the spiritual life has striking corollaries with CC theory and therapy. In Rogers’ (1959) theory, the actualizing tendency has only growth-promoting or life-maintaining properties. As Schillebeeckx (1980) asserts, God’s grace is similar. It empowers the good or only what enhances life (pp. 791, 808-815). CC therapists provide conditions in counseling that one can also predicate of God. According to Rogers (1957), a counselor seeks to understand their client’s inner experience or internal frame of reference. Because God is ever-present within us (Schillebeeckx, 1991, p. 57), the divine can be said to be “more intimate in me than I am … with myself” (p. 90); as such, we may assert that God understands our inner experience given God’s depth of intimacy within us. Rogers (1957) states counselors strive to have unconditional positive regard for clients. God, as pure positivity (Schillebeeckx, 1980, p. 727) and unconditional love (Schillebeeckx, 1987, pp. 104–105), may certainly be said to possess this attitude toward humanity. And, lastly, CC counselors endeavor to be congruent or aware of their inner reactions to clients in the counseling relationship (Rogers, 1957). God, who possesses absolute freedom, is entirely unencumbered by inner conflicts (Schillebeeckx, 1987, pp. 104–105; Schillebeeckx, 1991, p. 101). This implies that God is perfectly aware of everything that happens within the divine life (i.e., is congruent) as God relates to human beings. Thus, we see that God relates to us in a strikingly similar way to how CC therapists endeavor to relate to their clients, and, both relationships engender similar growth promoting tendencies for humanity.

Given all this, and in keeping with Rogers’ (1957) assertion that personality change will ensue for clients when counselors provide the conditions of CC therapy, it only stands to reason that Christian spiritual counseling—when grounded in a view of God and God’s relationship to humanity similar to the one outlined above—should be conducted in the same manner as CC therapy. This is posited not only because Rogers (1957) asserted that the therapist-provided conditions are responsible for all successful counseling, but also because Christian spiritual counselors should attempt to mirror the divine–human relationship as much as possible in terms of creating a climate
whereby unconditionality allows for client change. Just as Rogers (1961) states the climate of CC counseling promotes the client’s right to self-determination (pp. 170–171), so too should spiritual counselors seek to protect their clients’ freedom. This is important because, as DeMello (1990) asserts, the process of spiritual self-discovery and change comes from inner awareness of one’s process (pp. 45-50, 166-168), *not* from the direct guidance of a spiritual counselor. Moreover, Christian spiritual counseling should honor the freedom of the client because, as Schillebeeckx (1991) notes, God respects human freedom (p. 91). All of this supports the conclusion that Christian spiritual counselors should provide the right interpersonal environment within counseling—the same that characterizes CC therapy— which allows for self-discovery and change to occur. If a Christian spiritual counselor and client are endeavoring to work this way, it is only logical to assume that God’s grace will be at work in the inner process of the client, just as the actualizing tendency is at work in the client’s process within CC therapy.


“I Didn’t Know You Felt That Way”: The Practice of Client-Centered Couple and Family Therapy

Susan Pildes
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Abstract
Our client-centered counseling practice with couples and families is described. The nondirective attitude is our bedrock value. Our empathic understanding follows each person's expressed thoughts and feelings. With more people in the room, the situation is ripe for misunderstandings. Wanting to allow for correction from anyone present, we clarify our understanding of individual experiences and tend to share out loud the way we are following and understanding. In individual counseling, misunderstandings do not occur as often and this degree of explicit transparency seems less called for. Whether with an individual or with a couple or family, we are responsive to questions and requests.

In this paper we describe our way of implementing client-centered attitudes in couple and family counseling. We rely upon Carl Rogers’ (1951, 1957, 1959, 1961) attitudinal conditions of unconditional positive regard, empathic understanding and congruence, as sufficient for good counseling. The core value that pervades all of our work is the nondirective attitude (Brodley, 2011c; Moon, 2005; Raskin, 2005; Rogers, 1951). For couple and family counseling, we have found that sharing aloud our understandings and our intentions, is central to the understanding of others present, and to reducing the power of the counselor. What follows are thoughts we have articulated while discussing the questions that arise in day-to-day practice with families. Going forward, we will use the terms family and families as including both couples and families.
This description of how we work flows from six observations. 

I. We work with a nondirective attitude.
II. We implement the same theory (Rogers, 1951, 1959, 1961) for any number of people present.
III. Each family member is a separate individual.
IV. We try to be responsive to questions.
V. We seek to understand experiences within moment-to-moment interactions.
VI. We tend to say out loud our intentions as we speak.

The above six points overlap with how we work in individual counseling. We hope that the following discussion will illuminate the sturdiness of client-centered practice in family counseling.

I. A Nondirective Attitude

We work with a nondirective attitude, an indelible commitment to a non-authoritarian way of being. Our main intention is to understand and accept the self-expressions of family members. Apart from that, we have no goals other than those brought to us by family participants. Their goals may stay the same, or shift over time. We are not invested in keeping the family intact or moving it in any particular direction. We never fully know what is or is not best for any individual within the family. We have no conception as to what “the betterment of the family” would entail. We make no assumptions about a person's reasons for seeking help. We do not diagnose or assess and we do not set guidelines as to who should attend or participate.

Our only intention is to work in a client-centered fashion, following and understanding each person. In accordance with our nondirective attitude, we are responsive to individuals’ questions and requests (see also, Brodley, 2011c).

II. The Same Therapy for any Number of Persons

We practice the same client-centered counseling regardless of the number of people present in a meeting. In family counseling, as in individual counseling, our main intention is to understand individual thoughts and feelings about whatever is under discussion.
Functionally, what we do on any given occasion is to enter into a conversation with whoever arrives as a family group. We work to empathically understand the experiences of each person present, as we would to a person in individual counseling. However, while we are listening to and responding to one person, we are aware that others in the group will likely have their own, possibly very different viewpoints. These will get listened to and understood in turn.

Counselor: Jim, you are saying that you want us to talk about what happened last night. 
(To Mary) Mary, is that okay with you?

Listening and responding is a shared endeavor. It may be carried out by the counselor, or between any two family members without interference from the counselor – unless her understanding is faltering.

III. Each Family Member is a Separate Individual

We do not subscribe to any belief that groups a person within a class. Nor do we subscribe to any external point of view about what "family" is, what it should be, or what should be done to change this family. We favor seeking to understand individual’s values and perceptions. We are not assuming that “family values” are or should be shared by everyone present.

IV. We try to be responsive to questions

At times, one way or another, family members indicate that they would like to hear more of the counselor’s perspective. When asked for our opinion, we usually give it (see also Brodley, 2011c). We speak not as an expert, but as an attentive participant. We are willing to brainstorm with family members, and to share our thoughts and reactions. At times, this may leave us feeling as though we have become a temporary working member of the group.

When we speak, we tend to do so with awareness that we might be misunderstood. Our thoughts and suggestions are always offered with a tentativeness that allows for correction from anyone present.
V. Understanding Experiences Within Moment-to-Moment Interactions

Our intention in working with families is to understand. The only structure we bring to a session is following the expressed thoughts and feelings of each person present. In the course of following a conversation, we do not just switch back and forth between people as though we are listening to each person in a vacuum. Our responses often encapsulate a person’s experience in the context of more than one exchange. In the interest of everyone present having the opportunity to follow what is being said, we may request time for others to respond. For example, we might say:

Counselor: Robin, even though Brook has just said that he will go along with your idea, your sense is that he is still being dismissive of your thinking? I’m wondering if it would be okay for me to check with Brook and see if he does indeed feel that way?

In the example above, checking her understanding, the counselor is making a series of following connections.

Counselor: Robin, as Brook is describing that day I see you are shaking your head “no.” Is it okay with you if Brook finishes his point before you explain?

Or

Counselor: Brook, as you are speaking I see that Robin is shaking her head, “No.” Do you prefer to finish what you are saying before I ask her why she doesn’t like what you are saying?

Also, in the above three examples, the counselor is asking permission at points where she wants to check with the other person.
We tend to flesh out the complexity of the moment for each person as we understand it. This allows anyone present to follow and express disagreement with anything that has been said.

Below, in the midst of a family session, a mother and daughter are speaking directly to each other. At this point, the rest of the family is simply listening.

Counselor: Alice, you are saying this so loudly, really screaming your sense of helplessness. Right? You want her to stop and also you want her to feel terrible for how she is talking to you. Is this what you are saying?

Alice: Yes, because I just won’t listen to this anymore! The feeling of wanting to scream, to smack some sense into her, it’s just so strong.

Counselor: (Turning to Mia) Mia, I, I’m…

Mia: (Sobbing) I can’t believe you have so little self-control. You think it is ok to humiliate me.

Counselor: The way your mother yells at you, to you it feels deliberate, a deliberate attempt to humiliate you.

Although, it is not our intention to teach better communication, we find that it can be a side effect of this process. Each person having the opportunity to speak tends to put them in touch with their own thoughts and feelings and contributes to their being able to relax and let go enough to hear someone else. When a person is given the time and space to say what they actually think and feel about something, they can grow in self-acceptance and compassion both for themselves and for others. Our efforts to follow, understand and be clear can have the effect of an increased valuing of present feelings and an awareness that others have their own perspectives. Often in a session, a family member will suddenly say: “I didn’t know you felt that way”.

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VI. We tend to say out loud our intentions as we speak.

There are two reasons why we tend to say out loud our intentions as we speak. These reasons relate to our primary value, which is the nondirective attitude, and our primary intention, which is to understand.

At our best, in line with our primary value, we are not judgmental of anyone in the family and we are interested in and respectful of each person’s thoughts and feelings. We believe that our nondirective attitude becomes apparent in the way we work.

Our primary intention to understand requires that we be able to follow and attend to individuals. Checking back and forth between people, and occasionally asking people to wait so that we can ask a question for clarification enables us to follow and register what is going on between family members.

Within the complexity of a family session, speaking our intentions signals to family members how our understanding is proceeding. This allows for anyone present to correct any misunderstanding. We hope that working with the attitudes of client-centered therapy, with an additional weight given to explaining what we are doing, allows a sense of agency and freedom to develop within the people present.

With multiple people in the room, someone can easily feel disregarded or misunderstood. Sharing our intentions as we follow alleviates misunderstandings. It also relieves us of concern that we have lost or misunderstand someone's point, and allows us to be present as we proceed.

We speak with an awareness that there are different perceptions among those in the room (Brodley, 2011d; Moon, 2005; Rogers, 1961, p. 341). When responding to one person, we tend to be clear that we are relating our understanding of that person’s perception. The perception captured in the counselor’s response is the counselor's understanding of one person’s experience and not an objective truth. For example, the counselor might say:
Counselor: (Speaking to a father) Joe, even though your daughter has said that she doesn’t agree with you, and your wife, we might guess, has her own view too, you are saying that your family is accusing you for no reason at all. (The counselor’s response recognizes that each person present is likely to have their own perspective on what the father has said.)

Or,

Counselor: Pete, I am realizing that even though you were aware of Tom’s sense of urgency, you felt put out by his tone? Given that, you felt dismissed.

The above are two examples of an out loud sorting and acknowledgement of what’s being expressed. This gives people a chance to correct any misunderstandings and can help us all to process the information.

We frequently check to learn how one person feels in reaction to what another has said. Through the many moments of interaction, they have a chance to clarify their own perceptions. They seem to become more aware that other family members have their own perspective. It appears to us that feelings of compassion for self and others tend to grow within the environment we try to provide.

**Conclusion**

We have described what we are generally thinking and doing in our work with couples and families. Our intention is to understand and accept the experience of each person present. Because there are more people in the room, we protect our ability to follow by checking our understanding when we feel unclear. Although not our direct intention, this checking tends to slow down the conversation. Also, speaking our intentions out loud tends to minimize misunderstandings.

Family therapy can feel intense, chaotic, daunting and joyful. Session time can seem to fly. At times, when practicing client-centered...
family counseling, it appears that an interest and willingness to listen and understand with less judgment grows exponentially within the room. When a session is over, as the family leaves, regardless of whether someone is smiling or weeping, we can’t know what they will feel in ensuing hours, days and years. Ultimately, we never know what our work has or has not brought forth.
References


**Endnotes**

1 Readers interested in reading more on the subject of client-centered couple and family therapy will find annotated reviews of that literature within McPherrin (2005) and Motomasa (2004). Articles published subsequently to those include Brodley 2011a and 2011b, Gaylin, 2008, and O’Leary, 2015.
Real Human Connection: There is No App for That!

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Abstract

This paper focuses on the intersection of technology and the challenges that contemporary students face in managing their anxiety and forming social connections. College counseling centers across the country have seen a marked increase in students struggling with anxiety (Center for Collegiate Mental Health, 2017). We propose that this trend is intricately linked with technology: the bombardment of information from social media and news outlets can be overwhelming. While other generations certainly share in some of this experience, it is the current generation of college students that are affected most pointedly, having never lived in a world without texting, Instagram, Twitter and Snapchat. Broad suggestions for helping students navigate the unique challenges they face, drawing primarily on tenets of the person-centered theory developed by Carl Rogers are offered. The paradoxical remedy to the modern anxiety may be a return to a simpler, rather than a more complex strategy for intervention.

Technology is woven into the fabric of our society in an ever evolving manner. This phenomenon is neither inherently good nor bad,

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but the authors would hazard to say that there are consequences to such rapid and sweeping changes. In general, we are connected on a global scale: world events are streamed to phones, tablets and laptops. On college campuses, students are gazing into their smart phones with an expectant look that has become as ubiquitous as it is unique. The bombardment of information is continual, and at times, overwhelming. What is the consequence of this? A certain interpersonal disconnection is evident. The absence of non-verbal cues and emotional inflection lead to more shallow interactions (Lee, Leung, Lo, Xiong, & Wu, 2011). The current technological and informational explosion is unlike anything from the past. This is not the fault of this generation, who are immersed in this change--after all, previous generations have developed this technology.

**Technological Twist to Anxiety and Coping**

University faculty, staff, and administrators have worked to meet students in cyberspace; developing apps, learning platforms, and taking part in various social media. As well universities should—turning back the use of technology would be futile. The sun will rise in the east, water flows downhill, and students will interact on social media—these are inevitable facts. These efforts have had mixed results, however: Hung and Yuen (2010) report that when surveyed, students reported positive feelings toward learning experiences that included social networking as an adjunct to face-to-face class activities. Other researchers have reported that learning that took place solely on-line as opposed to face-to face was associated with a lack of a sense of community (Barbour & Plough, 2009), that participants were less satisfied in general and there was a dearth of emotional engagement (Mallen & Greene, 2003). In work done at counseling centers, Preschl, Maercker and Wagner (2011) found similar therapeutic gains occurred in group therapy on-line as compared to traditional in-person groups. Other researchers found some benefit to on-line delivery methods for therapy, but the gains were less robust than face to face therapy (Andersson & Cuijpers, 2009). Clearly there is promise to technology based interventions across venues, whether it is an adjunct to traditional methods or a standalone methodology, at the same time it is not a panacea, and there is much more research to be conducted.
In the past decade, according to a comprehensive survey by the American College Health Association (2015), anxiety has emerged as the chief concern of college students who seek help at university counseling centers across the country, hedging out depression, which still holds a prominent second place. In fact, 21% of women and 17% of men report experiencing at least one episode of overwhelming anxiety in the last year. Though this phenomenon is complex and only partially understood, what we do know is that students’ coping resources are outstripped by the demands that they face. Anxiety, at its core, is our psychological and physiological reaction to a threat. Although anxiety has increased, there does not seem to be in increase in actual threats or stressors for students, but rather in the ability to manage them. It is the authors’ assertion to look no further than social connectedness to find both the cause and the solution to this problem.

This anxiety is qualitatively different than simple worry—it has deeper, more existential roots: loneliness that is felt is pervasive and to the core of one’s being as young adults struggle to find their place in the world (Berman, Weams, and Stickle (2006). Existential anxiety, in and of itself is nothing new—with Kierkegaard (1964) writing about it in some depth. It was, and is a universal constant of sorts. It arises as we come to realize that our life has no meaning beyond that which we give it. Similarly, but from a more developmental perspective, Erikson (1966) suggests that this period from late adolescence to early adulthood is a period of identity development; solidifying who you are essentially. The responsibility of these daunting task gives rise to great anxiety. An interesting and complicated twist is the intersection between this anxiety and technology. While the technology connects us, this connection may lack a certain depth (Lee et al., 2010). The habit of turning quickly to our technology when an uncomfortable feeling arises is well entrenched. Unfortunately, this does not just occur during our down time, but also during class, while driving, while walking, during exercise, when hanging out with friends . . . and the list goes on.

One of the dangers of online interactions on social media is that it can replace face-to-face communication. Research shows that face-to-communication leads to an additional feeling of closeness compared to online communication (Lee et al., 2010; Mallen et al., 2003). Late night conversations in a study lounge, impromptu debates on the sidewalks, and simply being with friends has given way to
lightning fast strokes on touch screens. The ability to sit with others and even ourselves has declined. One of the primary ways in which we managed the existential anxiety of the past is through interpersonal support. The notion, that our relationships help us to manage the stresses and strains of living is well supported in the social science literature. For example, research has consistently found that there is a pretty compelling link between social connections and physical and mental health (Miki, Matheson, and Anisman, 2016; Thoits, 2011). In essence, people who reported having robust social relationships were healthier in a comprehensive sense.

Technology can interfere with the quality of our relationships but also helps us avoid sitting with uncomfortable emotions. Ironically, people report significantly less anxiety in on-line or other forms of electronic communication than they do when communicating in person (Shalom, Israeli, Markovitzky, & Lipsitz, 2015). On the other hand, this make intuitive sense, since most ways of managing anxiety require a confrontation of the anxiety in some fashion as opposed to simply avoiding it. Over the past few decades, the vital and diverse role that social support plays in our mental health has become well known: It serves to insulate us from mental health concerns. If adequate social support is present, students are able to manage life stressors, keeping them in check so they never become full-blown crises. And, when someone does experience a significant mental health concern, social support is associated with resiliency and the person connecting with the appropriate professional who can help them with their concerns (Cohen and Wills, 1985; Miki et al., 2005; Yakunina & Waehler, 2010).

The struggles faced by students are present across campuses throughout the nation. For instance, not long ago, two students, a man and a woman, were walking on a sidewalk in front of one of the authors. The young man began to say that he was thinking about dropping out of school. Just then there was an alert from the other student’s phone. Without thought, she quickly attended to her phone. She turned back towards her friend and said, “What did you say?” He replied, “Oh nothing.” These misses in communication have become far more common than they were a couple decades ago. Though it may seem like a distant memory when phones only hung on walls or sat on stands in houses, but this provided a boundary to such communication
that no longer exists, as carrying a phone throughout the day in all places has become the norm.

This is where the authors would argue that the university faculty and staff who lived in the era prior to instant communication have a responsibility. As noted earlier, it is previous generations, not the current cohort of students, who created this technological context. What can be offered to help students navigate life more effectively? Paradoxically, the authors assert that the answer to this problem is as simple as it is complex. First for the simple part: Make space for students to simply be—in the existential sense—to be with both others as well as with themselves. This work is underway at many institutions already. There is a trend across the nation to create learning spaces in libraries so that groups of students can meet and work collaboratively (Turner, Welch, & Reynolds, 2013). Similarly with the growth of Living-Learning Communities in residence halls, students have been able to form meaningful social connections to other students as well as faculty (Workman, 2015; Zhao and Kuh, 2004).

Rogerian Theory in Practice

So much for the easy part, now on to the hard part—how do we facilitate these interpersonal as well as intrapersonal experiences? We have to intentionally build a culture on campus where students are mentored, valued, and prized. College counseling borrows heavily from the work of Carl Rogers (1986) which spanned more than four decades. Rogers’ theory was heavily predicated on the formation of a relationship with others. The helper in the relationship must be genuine, congruent, and empathic. Also worth noting was that Rogers decided that his client-centered theory shifted to a broader person centered approach—beyond just therapy. Universities can examine a few of the key components to Rogers’ theory as it applies to our work on campus: To begin with we must be in a relationship with students. This is where the intentionality starts. We have to foster real opportunities for mentorships between faculty and staff and students. It is tempting to shift advising functions on-line. Computer algorithms are great for determining graduation requirements, but there is no substitute for a face to face conversation to determine if the student has made a thoughtful decision about selecting a major. Having simply decided on a major does not mean that the career decision process is
complete, and premature career foreclosure on this process can be deleterious to students’ academic progress as well as career trajectory (Cox, Krieshok, & Liu, 2016; Orndorff & Herr, 1997; Krieshok, 2001).

It would be great if class size would allow faculty to really know each student—but this is an ever-mounting challenge with budget constraints and pressures to grow enrollment. Between 2008 and 2015, all but three of the 50 states have decreased funding for higher education (Mitchell & Leachman, 2015). Having places where faculty, staff, and students can share space and interact in a casual fashion is important too. As noted earlier, many good changes are already underway with living/learning communities, such as more common space and organized social interactions. In fact, living/learning communities have been associated with higher retention rates (Buch & Spaulding, 2008) and increased student engagement in the university (Arms, Cabrera, & Brower, 2008). Though living/learning communities serve on-campus students well, what about students who do not have one of the identified special interest or who live off campus? The mentor relationship does not have to be the sage faculty who dispenses wisdom of the ages in the quad by the centuries-old oak tree. In reality, it is the clerk in the dining hall, who takes a little time to ask how a student’s day is—and cares. It is the RA who stops by just to say ‘hello.’ Absolutely nothing in Rogers’ theory dictates that the helper must be in a formal position of power. That being said, the president and the provost are not off the hook. Relationships take all forms.

Secondly, we must be genuine and congruent (Rodgers, 1986). The person in the helping role needs to have a genuine interest in the students and feel that they have something to offer within the helping relationship. The student, on the other hand, is incongruent; perhaps a bit anxious or unsure of themselves. The other part to this for the helper is that they must be genuine or true to themselves. We need to look for ways to be connected to students that feel natural to us. So often we put on a façade or assume a role of some sort. This is an impediment in really connecting with others. When who we are on the inside is who we are on the outside, forming real relationships is remarkably easy.

Next, we have to develop an empathic understanding for the students with whom we work and value them without condition.
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(Rogers, 1986). We have to not only care about our students, but we have to place ourselves in their shoes—as if we are them. It is critical here to not lose the ‘as if’ quality. This helps us to maintain our boundaries while respecting their autonomy. Being empathic does not mean that the student’s problem becomes our own. Similarly, having unconditional positive regard for them does not mean that we agree with everything they do, we just maintain our respect for their autonomy and for them as people.

Lastly, this empathic understanding must be communicated to the student (Rogers, 1986). This is actually one of the simpler aspects of this human equation. This is accomplished through a process of continually checking in. The relationship, in a sense, has to become part of the dialogue. Questions like, “How is this going?” and “Are we on the same page?” allow for a mutual evaluation and clarification of the relationship. In this way, the helper can emphasize their concern and caring for the student—even if this is not explicitly stated. This is a process of transparency. It is by no means necessary, and in fact is counterproductive, if the helper assumes the role of expert. The student is the expert in their own life—what has worked for the helper, may not work at all for the student. Remember, students likely have many people in their lives telling them what to do, and probably less than a few who truly listen.

Conclusion

Rather than to be prescriptive and give a list of specific things to do, in the spirit of the person-centered approach, a more flexible way of approaching the creation of a campus culture of real human connectedness was presented. In reality, every campus is unique—there are undoubtedly things that are done well (recognize and do more of them) and things that are not done so well (again, recognize these and look for ways to change). Being human is an ever-changing process—mistakes will be made in our roles as helpers, and that is OK. The more important thing is that we enter into the lives of students in effort to understand and mentor them. So, we know what to do—though we may need to remind ourselves—and by all means, put down the phone! Remember there is not an app for that.
References

American College Health Association. American College Health Association-National College Health Assessment II: Institutional Data Report Fall 2014 Emory University. Hanover, MD: American College Health Association; 2015.


Editors’ Introductory Commentary

The editors dedicate this issue to the memory of Barbara Temaner Brodley. Over the years for many of us, Barbara’s writings have proved to be invaluable in defining and clarifying the practice of client-centered therapy. Some of our graduate students remark that in studying Barbara’s writings, they feel as if they have “come home.” We are happy when this happens, but understand that client-centered practice is not for everyone. The papers found within this edition of the double issue of the Person-Centered Journal (PCJ), with the sole exception of the article by Daniel Metevier, were originally considered for inclusion in the collection of Barbara’s papers in the book edited by Kathryn Moon, Marjorie Witty, Barry Grant and Bert Rice titled Practicing Client-Centered Therapy, published by PCCS Books in 2011. Due to space limitations, we did not include them at that time, but are pleased to offer them here in this issue of the PCJ.

“Client-Centered Therapy What is it? What is it not?” argues for making clear distinctions between therapeutic practices which, while grounded in the principles and values of the approach, diverge from client-centered therapy. Barbara advocates identifying this larger family of therapies as “person-centered therapies,” of which client-centered therapy is a distinctive member/practice. Practitioners, it seems to us, are involved in a continual effort to define their own practices, and to attempt to identify when their practice is consistent with or when it departs from those practices to which they are committed. These divergences may lead to innovation and evolution, and they may represent mistakes and a falling short of the discipline of the approach. This paper presents some criteria for gauging whether or not we are practicing client-centered therapy and clarifies some of the misunderstandings which have grown up around the practice.

“A Client-Centered Therapy Practice” describes Barbara’s conclusions about her therapy, having observed its effects over many years and many clients. She enumerates the core values undergirding the practice of client-centered therapy, and identifies the processes of change which she has observed in her own practice with clients. The essay
provides a strong critique of directiveness and the subtle ways in which it may undermine the client’s self-authority and autonomy. Particularly helpful is the section on responding from the therapist’s frame of reference, in which she gives theoretically grounded justifications for therapist-frame responses.

“Some Differences in Clients’ Questions and Rogers’ Responses to Questions Between the Mr. Bryan Sessions and Rogers’ Post-Bryan Therapy Sessions” is a paper that presents some of the findings of a dissertation by Claudia Kemp. Barbara was a member of Kemp’s dissertation committee, and in this article they focus on revealing the ways in which Rogers’ behavior changed after his work with a client named Mr. Bryan. Brodley and Kemp contend that Rogers was not yet a client-centered therapist when he worked with Mr. Bryan, but he was on his way toward developing into the client-centered therapist he came to be known for.

Finally, we include an interview with Barbara, conducted in 2002 by Daniel Metevier. The interview is part of his dissertation on client-centered supervision. Dan’s interview questions helped to explicate Barbara’s development as a consultant (she eschews the term “supervisor”), including her distinctions between the attitudinal conditions provided as therapist and the same attitudes involved in the consultative relation. She describes working with a range of students, some of whom do not really aspire to practice from the client-centered approach and some of whom welcome and are open to Barbara’s open and honest feedback on their work. For those of us involved in providing supervision/consultation, we hope this essay illuminates how a master client-centered therapist conveys the practice.

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Carl R. Rogers, the originator of client-centered therapy, did not intend to found a school of psychotherapy with a set practice. Instead, he worked with his clients, reflected on the therapy process and, at a certain point, he advanced a set of hypotheses (1957) about the causes of constructive personality change. He presented the theory so it could be tried out by others and so it could be used as a basis for further research on psychotherapy.

Rogers thought his theory was an approximation to the truth about therapy. But he was, also, committed to protecting and encouraging a spirit of experimentation, discovery and creativity about psychotherapy. He did not want client-centered therapy to be ‘frozen’ but, rather, to be a working hypothesis, a stimulus to further inquiry about the therapy process. Rogers always has been committed to promoting openness, growth and change in the pursuit of truth about therapeutic process.

He has always encouraged and supported research projects and theorizing by others. And, very importantly, his presentation of the theory in terms of attitudinal conditions, not techniques, fostered openness to different ideas about therapeutic practice. His theory left it up to the practitioner to choose which behaviors or techniques could be used to communicate the therapeutic attitudinal conditions to the client. This development in client-centered theory opened the way for practitioners from many different therapeutic schools to incorporate the basic premise and the hypotheses of attitudinal conditions into their own therapy without abandoning their original orientations. It also set

¹ Editor’s Note: Presented at the First Annual Meeting of the Association for the Development of the Person-Centered Approach which met in Chicago, Illinois at International House on the University of Chicago Campus September 3–7, 1986.
the stage for the creation of a variety of new therapeutic methods based on the fundamental principles of client-centered theory.

It is my impression that there are many different therapy practices, and more therapies continually developing, which share the basic theory of client-centered therapy. This situation, of many evolving therapies which are often referred to as client-centered therapies, is confusing to students and confusing when one wishes to discuss differences in therapy practice with colleagues.

I think it would clarify this situation to classify a therapy practice as a person-centered therapy whenever a therapist is trying to work from the basic hypotheses: the inherent growth principle and the major attitudinal conditions for constructive change. Once this classification is made, we can distinguish among the various person-centered therapies by their observable form, or their techniques, or by the additional principles, values or theoretical elements they encompass.

I believe there are many evolving person-centered therapies and the practice of client-centered therapy is one of those. Client-centered therapy can be described in terms of the theory it shares with the other person-centered therapies and by its distinctive features.

My view is that client-centered therapy is a distinctive and important practice and that it can be defined as a practice and its parameters clarified. I do not believe it would, by defining it in a delimiting way, become static or not evolve further. Rather, its evolution would be conceived within certain limits. Functioning therapeutically outside those limits would be considered, perhaps, a new and other person-centered therapy. Or someone might, also, be developing a practice outside the defined limits of the person-centered therapies. Certainly many of those already exist. The point is, this system of classification gets around the problem of freezing client-centered therapy but also permits distinctions in respect to the practices of therapy that are out there in the reality of therapeutic work.

The differences distinguishable among person-centered therapies probably make substantial differences in the experience of therapy by both client and therapist and make differences in what is observable on tapes and films and, probably, make differences in the effects of the therapy on the lives of its clients. We can study and
understand these different effects much better if we distinguish practices. But most important to me, the clarification and definition of client-centered therapy as distinguishable from other person-centered therapy practices can contribute to the presentation and evolution of this unique and extremely effective way of working with clients. I have felt for some time that client-centered therapy has been misunderstood, underestimating and underused, in part, because of its ambiguities as a practice and because of its confusion with other person-centered therapeutic practices.

**The Person-Centered Approach**

Rogers has recently stated the basic hypothesis and the therapeutic conditions that distinguish the person-centered approach as follows: The central hypothesis of this approach can be briefly stated. It is that the individual has within him or her vast resources for self-understanding, for altering her or his self-concept, attitudes, and self-directed behavior – and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided.

There are three conditions which constitute this 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, in any situation in which the development of the person is a goal. I have described these conditions at length in previous writings (Rogers, 1959, 1961). I present here a brief summary from the point of view of psychotherapy, but the description applies to all of the foregoing relationships.

The first element has to do with genuineness, realness, or congruence. The more the therapist is him or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner.

The second attitude of importance in creating a climate for change is acceptance, or caring or prizing – unconditional positive regard. It means that when the therapist is experiencing a positive, nonjudgmental, accepting attitude toward whatever the client is at that moment, therapeutic movement or change is more likely.

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The third facilitative aspect of the relationship is empathic understanding. This means that the therapist senses accurately the feelings and personal meanings that are being experienced by the client and communicates this acceptant understanding to the client (Rogers, 1986).

Additional assumptions, beliefs and hypotheses that are central to the person-centered approach are the following: 1. Belief that human nature is basically constructive. 2. Belief that human nature is basically social. 3. Belief that self-regard is a basic human need and that self-regard, autonomy and individual sensitivity are to be protected in helping relationships. 4. Belief that persons are basically motivated to perceive realistically and to pursue the truth of situations. 5. Belief that perceptions are a major determinant of personal experience and behavior and, thus, to understand a person one must attempt to understand them empathically. 6. Belief that the individual person is the basic unit and that the individual should be addressed, (not groups, families, organizations, etc.), in situations intended to foster growth. 7. Belief in the concept of the whole person. 8. Belief that persons are realizing and protecting themselves as best they can at any given time and under the internal and external circumstances that exist at that time. 9. Belief in abdication of the pursuit of control or authority over other persons and, instead, a commitment to strive to share power and control. 10. A commitment to open mindedness and humility in respect to theory and practice.1

The basic hypothesis, the theory of therapy and the additional beliefs stated above describe the person-centered approach. They are elements I believe are usually shared by the people practicing the various person-centered therapies including client-centered therapy. These shared elements do not, however, distinguish client-centered therapy from the other person-centered therapies. The following discussion is an attempt to define and discriminate the practice of client-centered therapy.

**Client-Centered Therapy – What is it?**

First, client-centered therapy is distinguishable by its form. The salient form of client-centered therapy is the empathic understanding response process (Temaner, 1977). The empathic understanding response process involves the therapist maintaining, with consistency
and constancy, the therapeutic attitudes in his/her experience and expressing him/herself to the client through empathic understanding responses. Please turn to the appendix of this presentation for four segments of therapy sessions which can serve as illustrations of empathic understanding response process.

Empathic understanding responses are the observable responses which communicate empathic understanding to the client. They are responses intended to express and check the therapist’s empathic understanding experience of the client. In a given empathic understanding response process between therapist and client many different types of empathic understanding responses may be involved. Examples of common types of empathic understanding responses are the following: literal responses; restatements; summaries; statements which point toward the felt experience of the client but do not name or describe the experience; interpretive or inferential guesses concerning what the client is attempting to express; metaphors; questions that strive to express understandings of ambiguous experience of the client; gestures of the therapist’s face, hands, body; vocal gestures, etc.

What makes these types of response function as empathic understanding responses is that the therapist expresses them to the client with the intention to ask the client – ‘is this what you are telling me?’ or ‘is this what you mean?’, or ‘is this what you are feeling?’. These types of response, and others, may be the vehicle for the expression of empathic understanding as long as their sole intended function is to help the therapist in his attempt to understand the client’s internal frame of reference as the client is searching himself and communicates to the therapist.

The empathic understanding response process can appear to be very different from therapist to therapist, and between therapies with different clients by the same therapist, depending upon the types of responses which are used by the therapist. The particular way the therapist expresses empathic understanding to the particular client does not matter, from the point of view of remaining within the client-centered framework, however, as long as the way communicates to the client the therapist’s intention to understand and as long as the client feels understood by the therapist.

Client-centered therapy is also distinguishable by the extreme emphasis the practice places on the non-directiveness of the therapist. In client-centered therapy the therapist is intensely mindful to respect
and protect the autonomy and self-direction of the client. The client is viewed as the expert about himself and the therapist views himself as expert only in maintaining the attitudinal conditions in the relationship with the client, not as an expert on the client.

The therapeutic relationship is inherently an unequal relation in which the client is self-defined as vulnerable and in need of help and the therapist is self-defined as one who can help. An element in the person/client-centered perspective is the belief that unequal relationships are naturally, to some extent, hurtful or harmful to the persons involved in them.

Unequal relationships are sometimes necessary, for example, the physician and patient or the teacher and student, because they offer desired benefits. But the person/client-centered perspective fosters the abdication of the pursuit of power and would argue for minimizing the hurt or harm by sharing the authority as much as possible.

The client-centered therapist is particularly mindful of the harmful potential side-effect of the unequal therapeutic relation, and tries to share his authority as much as possible. This awareness and effort influences all of his actions in relation to the client. Basically, the client-centered therapist’s view on this matter is — the authority for the client’s experience is the client and the way the client uses the relationship is always left up to the client.

This non-directive attitude has a significant influence on the way therapy is conducted, influencing what is done and what is not done. For example, the client-centered therapist answers client’s questions. Obviously, if the therapist decides what questions it is appropriate to answer, or takes the view that certain questions are expression of a client’s avoidance of something and the therapist interprets this to help the client get on the right track, or if the therapist takes the view that the client’s question is an aspect of seeking dependence on the therapist and the therapist raises this interpretation, then the therapist is acting in ways that direct the client’s process. From a client-centered viewpoint, the idea that the therapist should evaluate the desirability for the client of having his questions answered is paternalistic and an exercise of authority over the client.

A client-centered therapist remains free to not answer a question asked by the client. But the reason for not answering would be explained to be a personal one — the therapist feels he does not know enough, or he feels uncomfortable in divulging the particular
information, etc. – not as something that is good for the client. There are many, many implications for the way therapy is practiced when the client-centered therapist is acting from this strongly felt attitude that the client is his own best expert and that the therapist maintain non-directiveness.

The non-directive character of client-centered therapy is not only for the purpose of protecting the client’s autonomy and to enhance the client’s self-direction. Client-centered therapy is a fundamentally non-directive therapy because being so contributes to the distinctive therapeutic quality of the relationship between therapist and client. This quality involves the fostering in the client of a combination of feelings – of freedom, of a positive sense of self, and of empowerment. The therapist provides the basic therapeutic attitudes of congruence, acceptance and empathy. He combines these in his way of being, with non-directiveness – the absence of directive attitudes and behaviors that would determine the content of the client’s expression, or determine the processes that take place in the client. This whole way of being produces a unique experience of an authority (the therapist, inherently an authority) consistently behaving in a non-authoritative manner. This abdication of the usual forms of authority carries meaning to most clients. It conveys that they are not being evaluated, not being supervised and not being controlled. That they are not being treated in these usual ways by an authority also carries the meaning that they are being treated with respect, are being trusted, and are free, to a great extent, in the relationship. As a consequence the relationship takes on the qualities referred to above, of freedom, of enhancement of the client’s sense of self and sense of personal power.

Client-centered therapy is a practice in which the hypothesis of the inherent growth principle is put into action. It is also a therapy wherein the theory of therapeutic attitudes as conditions for growth is taken as the basis for functioning with the client. It is also a therapy practice that is distinguishable by the form that it usually takes (or the form it reverts to if other forms come into play) – the empathic understanding response process. It is also a therapy, which emphasizes non-directiveness and wherein this principle is maximized in the relation with the client. All together, these features distinguish
client-centered therapy from other extant and possible person-centered therapies.

**Client-Centered Therapy – What is it not?**

In the world of psychotherapeutic practices client-centered therapy *is not many things*. The following list of *things it is not* will be limited, however, to those things it is sometimes thought to be by people who have a familiarity with the approach.

1. Client-centered therapy is not the technique of ‘reflection of feeling’ or making ‘empathic understanding responses’. Any outward form of an art (and therapy is an art) may be looked at as a technique. It may be useful to look at the reflection or empathic understanding responses from the point of view of technique but this should be understood as an abstraction and contrary to the spirit of their actual production. Only if empathic understanding responses, (or any other types of response used in the context of client-centered therapy), are used as expression of the therapist’s genuine attitudes of congruence, acceptance and empathic understanding are they an expression of client-centered therapy.

2. Client-centered therapy is not identical with the empathic understanding response process. This is so even though the process is the salient form of interaction in relationship of client and therapist and even though this form is one of the identifying features of client-centered therapy. Empathic understanding response process (EURP) is not identical with the total therapy for three main reasons. First, the functions of the therapist are more than the EURP. The therapist’s adaptation to the individual client as a person in a concrete relationship situation requires the application of the hypothesis and the therapeutic conditions in many ways, including the set up of the therapy, the adjustments in language for the sake of mutual understanding, and the social aspects of the therapy situation.

   Second, the EURP is an optimal process, as a means to express empathic understanding and express the other therapeutic attitudes to the client, for most clients who choose to engage in therapy and wish to talk about themselves and their problems. But client-centered therapy is not limited to this population of clients. The realization of the theory of therapy with clients who do not choose therapy, or clients who are unable to talk about themselves, or clients whose illness or...
defects distort their relation to reality or to a relationship, may require forms of interaction which appear quite different from empathic understanding response process.

Third, there are, in the usual therapy situation when EURP is the salient form, often other forms of interaction which occur in the practice. These forms, such as answering questions, giving explanations, shaping experiments for the client to try, etc., occur in and may be an integral part of a particular therapy relationship. These forms occur in client-centered therapy, however, only when they are requested by the client or when they become the way to be with the client that gets clarified out of expressed needs or desires of the client. If forms of interaction other than EURP occur in a particular client-centered relation, the way they are expressed or done is shaped by the belief in the growth principle, the presence of the therapeutic attitudes in the therapist and the non-directiveness of the therapist.

3. Client-centered therapy is not based on a belief in any particular therapeutic process occurring in the client. Even if it were to be shown that the most therapeutic process in clients is a particular way of expressing the self, or a particular way of relating expression to inner experience, or particular feelings developing toward the therapist, or a particular pattern of insights, or any other idea about how the client should act or feel or express – as the maximally therapeutic way – (and nothing of the sort has been shown so far), client-centered therapy would remain non-directive and open to the process that emerged in the client and would not involve trying to influence that process.

It should be obvious, that to hold the view that a particular way of functioning by the client in the therapy relation is the way to make happen would necessarily involve some form of directiveness and be inconsistent with the basic conception of client-centered therapy. Given the premises of client-centered therapy, it is not possible to justify directiveness regardless of the advantages that might derive from directiveness in a particular instance.

4. Client-centered therapy does not excessively restrict the therapist’s resourcefulness as a helper. This is the case in two different ways. First, within the framework of client-centered therapy as defined above, it is possible for therapists, depending upon their talents and the psychotechnologies they have learned, and if they are so inclined, to utilize techniques identified with other types of therapy. Techniques
of, for example, behavioral therapy, cognitive therapy, gestalt therapy, hypnosis, focusing, relaxation, meditation, etc., may be brought into the context of ongoing client-centered therapy. But – and this is a restriction – the client-centered therapist would bring these in only at the request of the client or when the interaction brings out in the client an awareness of needs that might be met by such techniques. The client-centered therapist does not, as said before, have any convictions prior to the therapy about what process in the client, or what ways of helping, a client may need. These techniques and psychotechnologies may, then, be incorporated into a specific course of client-centered therapy, as long as the therapist is not imposing them and the client is given control of the occasions and limits on their use.

The second way the therapist is not restricted in the forms of help that may be given to the client is that the client-centered therapist may serve as a source of information about other therapies or treatments and as the person who helps the client utilize the therapies or treatments provided by others. Sometimes helping the client utilize other therapies means minimizing their damage to the client that takes place as they are benefiting him. Until other helpers – physicians, psychological and behavioral therapists, psychopharmacologists, etc., are, themselves, person-centered, it remains the case that many of these experts violate the self-regard or the autonomy of their patients and clients.

The client-centered therapist performs a crucial service in maintaining the basic client-centered therapeutic relation while his client goes through various treatments and therapies. These treatments may, in their specifics, be helpful to the client – even necessary – for his well-being. But without the grounding in the client-centered relation the client may be totally unable to use the services of these experts, or may be hurt or damaged in the process.

In the same way that the nature of client-centered therapy, in providing optimal conditions for growth and change, facilitates the client’s constructive experience of, and way of relating to, his world, it also facilitates the client’s strength, confidence and good judgment in utilizing the resources of the world, including its myriad therapies, treatments and educational and remedial resources.

5. Client-centered therapy is not inhibiting or restrictive to the natural personality of the therapist. It is true that the person who has strong tendencies to control others or to dominate others is not likely
to take on client-centered therapy as his way of working. But if the basic person-centered values feel right to the therapist, the development of its disciplines will tend to feel self-realizing, not self-restricting. Also, within the framework of client-centered therapy there is great freedom for individual personalities. The therapeutic attitudinal condition of congruence, the realness of the therapist, the avoidance of a role fosters the development of individuality (and the client’s perception of that individuality) in the therapist’s presence with the client.

There is a marked similarity among client-centered therapists in their shared values and in the salient form of the therapeutic relation – the empathic understanding response process. Within that form, however, the unique mind and experience of a therapist shapes his empathic grasp of the client’s presented experience and shapes the specific responses that are expressed to the client.

Individuality is also expressed in the extent of personal openness and the qualities brought out in self-disclosures when they are in answer to personal questions by the client or when they are an expression of congruence.

The natural personality of the therapist is generally enhanced and developed by the practice of client-centered therapy itself. The practice requires the development of the attitudinal conditions in relation to clients. In this development, for that context, the client-centered therapist tends to develop those qualities towards himself and is, thereby self-therapeutic and self-fostering of his own individuality.

6. Client-centered therapy is not based simply on what works. It is based on what works within the parameters of what expresses and maintains the client’s experience of the attitudinal conditions and of the therapist’s non-directiveness and does not contradict the presence of these conditions. If what works also jeopardizes the client’s sense of safety and freedom, or undermines the client’s self-regard, his feelings of confidence in himself, or his sense of autonomy, then what works in those cases is not sufficient to justify employing it.

The achievement of insights, or the reduction of specific symptoms, in client-centered therapy, is only considered therapeutic if it is in the context of the larger perspective of preserving the therapeutic attitudinal qualities of the relationship perceived by the client.
Client-centered therapy stems from ethical values and beliefs, even though they are held with the reservation that they are hypotheses. These values assert respect for the individual person and the belief that unconditional caring for the person is constructive for the person and also for the social milieu of the person. Whatever scientific support there may be for the client-centered theory of therapy – and there is considerable support for it (Patterson, 1984), the science is not the start of the practice for the practitioner. It simply gives support for where we place our faith. Because no-one knows the truth about therapy and no-one knows what is right.
References


Brodley, B.T., & Lietaer, G. (2006). *Transcripts of Carl Rogers’ Therapy Sessions*, Vols. 1–17. Available from germain.lietaer@psy.kuleuven.be and kmoon1@alumni.uchicago.edu


Segment I

C29: I was thinking the other night, I was feeling very blue about the way I felt, and I thought, well... maybe, I wish I had my mother here in the way that she was, because she used to be... sort of reassuring when I was ill and she would do little things, and make some special dish, like custard or something. It was sort of reassuring sort of to have her around. (T: Mhm) And, of course, I know that she isn't able to be that way any longer. I don't know what it all means, but for a minute I thought I really miss her. I sort of need a mother at this point and yet that's sort of impossible...

T29: But even though it's factually impossible, the feeling was... 'Gee, I miss her, I wish she was here to take care of me and look after me'. (C: Mhm)... (19 sec. pause)

C30: And yet at the same time I felt, well - a little later, so - I thought that... maybe that wasn't what I needed, maybe it was a more adult... sort of... companionship or something in some way, rather than a mother. But I needed something or somebody...

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2 In the course of many years, Barbara transcribed and supervised others in transcribing Rogers’ therapy and demonstration sessions. In 1986 the two appendix transcripts of Rogers work (I & II) contained more omissions than they do now. At some point, Barbara began the process of “polishing” them through multiple listenings of the tapes. Her transcript work culminated in a joint effort with Germain Lietaer to transcribe for purposes of study and research all of Rogers available sessions (Lietaer & Brodley, 2003) and to share them through an informal email publication (Brodley & Lietaer, 2006). We have updated this appendix with the 2006 version of these segments selected by Barbara in 1986.
T30: You really didn't feel sure in yourself whether... what you wanted was someone to really... give you close mothering... or whether you wanted some more... grown up kind of relationship...

C31: And then, in another sense, I thought, well... maybe it's just something I have to go through alone.

T31: Maybe it's just hopeless to wish that I could really be in a relationship with anybody... Maybe I have to be alone.

C32: The thing that sort of has thrown me this week is that... well, I feel better about the physical condition I talked of last week, and I sort of made friends with my doctor which makes me feel a little better, as though we're not going to be quietly fighting without saying anything. And I think that I have more confidence in my medicine. I read an article about this and it said it's very hard to diagnose, so I don't hold that against him. But he feels he has to be sure, sort of... (words lost) giving me X rays and I'm frightened because I kind of feel that they're trying to be sure it isn't cancer. That really frightens me terribly (T: Mhm), and.... I think it's when I let that... thought come to me, maybe it is and what if it is and... that's when I felt so dreadfully alone.

T32: HmHm... You feel if it's really something like that... then you just feel so alone. (8 sec. pause)

C33: And it's really a frightening kind of loneliness because I don't know who could be with you... and it seems rather. (7 sec. pause)

T33: Is this what you're saying? 'Could... could anyone be with you in... in fear, or in a loneliness like that'? (Client weeps) (30 sec. pause) Just really cuts so deep. (C shakes her head) (13 sec. pause)

C34: I don't know what it would feel like if there were somebody around that I... could feel sort of... as though I did have someone to lean on, in a sense... I don't know whether it would make me
feel better or not. I was trying to think, well, it's just something that you have to grow within yourself... Just sort of stand... even just the thought of it, I mean, it'll be two weeks, I suppose, before they know. Would it help to have somebody else around, or is it just something you just have to... really be intensely alone in? And that's the... well, I just felt that way this week, so dreadfully, dreadfully, all by myself sort of thing. (T: Mhm)

T34: Just a feeling as though you're so terribly alone... in the universe, almost, and whether... (C: Uh-hum) whether it even - whether anyone could help - whether it would help if you did have someone to lean on or not, you don't know. (15 sec. pause)

C35: I guess probably basically, that'd be a part of it you would have to do alone. I mean, you, just couldn't take anybody else along in some of the feelings; and yet, it would be sort of a comfort, I guess, not to be alone.

T35: It surely would be nice if you could take someone with you a good deal of the way into your... feelings of aloneness and fear. (14 sec. pause)

C36: I guess I just have. (20 sec. pause)

T36: Maybe that's what you're feeling right this minute. (19 sec. pause)

C37: And I think it is a comfort. (Long pause - 1 min. 27 sec.) And I guess the feeling I have now is, well, I'm probably looking on the very blackest part of it. And maybe there's no real need for that... I mean I... It may just take time to reassure me. (5 sec. pause) And then this will all be sort of unimportant (mhm), although it's something I shan't forget, I'm sure (Laughs) (T: mhm)...  

Segment II

C27: Well, it's just the same old story—mothers and fathers try to tell the kids what to do and the kids revolt. (T: Uhm, hmm.) So that’s the only thing right now--between my parents and me.

T27: Uhm, hmm. So I guess you're saying this is true in general, but it’s also true of you--that your parents try to tell you what to do, and you feel, "I won't take that."

C28: Well, I don't feel it--I say it. Of course what I say and what I do are two different things, though.

T28: M-hm. I’m, uh, I'm not quite clear there, you say... um...(C: Well uh,) you say it, but you don't really feel it?

C29: Well, uh, let's put it this way: if my mother tells me what to do, and whether I like it or not, I have to do it. But, boy, I let her know that I'm not too happy about having to do it either.

T29: Uhm, hmm. Are you saying there, "She may be able to, uh, make me behave in certain ways or make me do certain things, but she can't control the way I feel, and I let her know how I feel."

C30: That's exactly it. (T: Uhm, hmm.) And about twice that damage. That's about two times of it straight in a row. I think she usually gives in. (T: Uhm, hmm.) Saves a mess and bother to me of...I hate breaking dishes and stuff like that.

T30: (Laughs.) So, uh, are you saying that when you stand up on your hind legs strong enough a couple of times in a row, then no matter what she thinks, she kind of gives in to save the broken dishes?

C31: Well not the broken dishes. Just she sees that, uh, she's gone a little too far. (T: Oh.) See, I have a stepfather.

T31: I see.
C32: And uh, well, let's put it this way, my stepfather and I are not on the happiest terms in the world, and so when he states something, and of course she goes along, and I stand up and let it be known that I don't like what he's tellin' her. Well, she usually gives in to me.

T32: I see.

C33: Sometimes, and sometimes it's just the opposite.

T33: Uhm, hmm. But, uh, part of what really makes for difficulty is the fact that you and your stepfather, as you say, are not, uh, the relationship isn’t completely rosy.

C34: (C laughs a little) Let's just put it this way, I hate him and he hates me and it's that way. (Pause of 5 seconds)

T34: But that you really hate him and you feel he really hates you.

C35: Well, I don't know if he hates me or not, but uh, I know one thing, I don't like him whatsoever.

T35: You can't speak for sure about his feelings, cause only he knows exactly what those are, but as far as you're concerned...

C36: He knows how I feel about him.

T36: ...you don't have any use for him.

C37: Not whatsoever. And that's been for about eight years now.

T37: So for about eight years you've lived with a person whom you have no respect for and really hate.

C38: Oh I respect him. (T: Ah.) I have to respect him. I don't have to, but I do. But I don't love him. I hate him. I can't stand him.
T38: There are certain things you respect him for, but that doesn't, uh, alter the fact that you definitely hate him and don't love him.

C39: That's the truth. I respect anybody who has, uh, bravery and courage, and he does. (T: Uhm, hmm.) And uh, I still at that, though I respect him, I don't like him.

T39: Uhm, hmm. But you will, uh, you do give him credit for the fact that he's brave. He's, (C: He...) he has guts or something.

C40: Yeah. He shows that uh, he can uh, do a lot of things that uh, well a lot of men can't. (T: Uhm, hmm. Uhm, hmm.) And also he has asthma, and the doctor hasn't given him very long to live. (T: Uhm, hmm.) And uh, he, even though he knows he's going to die, he keeps workin'. (T: Hmm.) And he works at a kiln factory. So I respect him for that, too.

T40: Uhm, hmm. So I guess you're saying he really has, um…

C41: What it takes.

T41: Quite a few. Yeah. He has what it takes, in quite a few ways, and a number of good qualities. But, uh, that doesn't, uh, mean that you care for him at all, (C: Yeah.) quite the reverse.

C42: That, that is the truth. The only reason I, uh, put up with, uh, being around is because for my mother's sake.

T42: Uhm, hmm. (Pause of 6 seconds) If it weren't for her, you feel you'd just, wouldn't stand it.

Client: I was angry. (T: Um.) I was so angry. And it’s good for me that I’m taking all this time before I go to Greece, I, I mean this workshop now, and then I’m going to travel. And then I’m going to go to Greece at a certain point in August. (T: Uh-huh.) But sometimes, I just, I’m struck by the fact that, gosh, I’m going to see them again, and how would that be? How will that be?

Therapist: You’re making it gradual and yet at a certain point you will be there, (C: Uh-huh.) and what will that be? (C: Uh-huh.) Is … you have, uh, an … anticipation or fear (C: Yeah.) or (C: Yeah.) something like that …

Client: Yeah, and I guess … I was thinking about my mother the other day, and … I realized, in the States I realized that she and I had a very competitive relationship. And – it was interesting but, three days ago in Budapest, I saw a lady in the street who reminded me of my mother. But, my mother, not at the age which she has right now. But my mother twenty years from now. And, I don’t know why. I was so struck by that, because I saw my mother being old and, and, weak. So she was not this powerful, domineering person that she used to be in Greece which I was so much afraid of. (T: Uh-huh.)

Therapist: But old and weakened and diminished …

Client: Diminished. That’s the word. (T: Uh-huh.) That’s the word. (Client begins to show emotion of crying)

Therapist: And it moved, kind of moved you to think of that, that she would (C: Yeah.) be so weak and diminished.

Client: And I think there was something in that lady’s eyes that reminded me of my mother which (voice breaks – crying) I was not aware

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3 From a demonstration interview by Barbara Temaner Brodley in Szeged, Hungary, 1986 that was later published (Brodley, 1999).
of when I was in Greece. And it was fear. (T: Uh-huh.) I saw fear in the woman’s eyes. (T: Fear.) Yeah. And, I was not aware of that.

Th: You mean, when you saw this woman who resembled your mother but twenty years from now, you saw in this woman’s eyes something you had not realized was in fact in the eyes of your mother. (C: Yeah.) And that was the quality of fear. And that had some great impact on (C: Yeah.) you.

Cl: Because I felt that. This woman needed me. It feels good that I am crying now. (T: Uh-huh.) I’m feeling very well that I am crying. (T: Uh-huh.)

Th: That it was also that, that it was a sense of your mother at the future, and that your mother will need you.

Cl: You got it! The future stuff. It’s not the present stuff. (pause) It feels right here. (She places her hand over her abdomen.) And as I am going back to Greece – I don’t know if I’m ready to, if I’m ready to be ready to take care of her. I don’t know if I’m ready to see that need expressed by her. (Client has continued to cry as she speaks.) (Th: Uh-huh, uh-huh, uh-huh.) (pause)

Th: You’re afraid that when you get there that will be more present in her or you will see it more than you did before, now that you’ve seen this woman, and that that will be a kind of demand on you and you’re afraid that you’re not ready to meet that.

Cl: That’s it, yeah, and it’s gotten too much for me. Or, I right now in Buda … in Hungary, I perceive it as being too much. (crying continues)

Th: Uh-huh. At least, you’re saying you’re not sure how you will feel there, but it feels now like if that comes forth, if you see that, you, you won’t be able to (C: Take it.) respond – be able to take (C: Yeah.) it. (C: Yeah.)
Segment IV 4

Cl: Probably, my, my fear, fear for my need for a relationship, (laughs) too has to do with irrational feelings too (T: Hm, hm) you know uh … it has probably to do with, with some kind of parenting that I didn’t get, I am still seeking, that I will never get you know (T: Hm, hm) trying to be taken care of by somebody. (laughs)

Th: Your need for relationships is based on irrational feelings (Cl: Yeah) that’s what you are saying.

Cl: That’s only partly so (T: Hm, hm) you know.

Th: It’s like, the parenting you missed, the need for being parented, it’s like you are going to get now, if you have a relationship (Cl: Yeah) wanting to be taken care of, it’s very important now.

Cl: Yeah. I think that is one of the things I will be expecting in a relationship is, some, some kind of … being taken care of, you know, (T: Hm, hm) somebody taking care of me, but, you know, it is unrealistic, but I suppose I will always have that feeling that I want somebody to take care of me, you know.

Th: What you are expecting in a relationship is that someone take care of you (Cl: Yeah, (laughs)) but you think it is unrealistic probably (Cl: Yeah) to expect that, (Cl: Yeah, I guess so) to want someone to take care of you.

Cl: Yeah. (yawns) I, I don’t know, that’s for me like, taking care of somebody else, you know, if I have to (laughs).

Th: Hm, hm.

4 From an interview by Usha Surabhi with a client, 1986.
Cl: It’s a tremendous burden to expect somebody else to do that for you … uh.

Th: It’s a tremendous burden to expect someone else to take care of you.

Cl: Yeah, yeah … but I still have these thoughts, these childhood feelings that I am still looking … for someone to take care of me.

Th: Hm, hm. You still have … these childhood feelings (Cl: Yeah) strong needs … to be taken care of.

Cl: Yeah. I think I see, here again, here we go back to gambling now. It’s all kind of tied in, tied in to gambling. (T: Hm, hm.)

Endnotes

i These are discussed further in ‘The Core Values and Theory of the Person Centered Approach’ by Jerold Bozarth and Barbara Temaner Brodley presented at the First Annual Meeting of the Association for the Development of the Person Centered Approach which met in Chicago, Illinois at International House on the University of Chicago Campus September 3–7, 1986.

ii This statement is from the perspective of the client centered therapist not the client. The client is the judge, for himself, of whether or not any therapy or treatment or technique is therapeutic for him, and of whether or not the benefits he has received outweigh what he may have suffered.

iii The first segment is a transcript from a film of Carl Rogers with ‘Miss Mun’. The second segment is part of a therapy interview by Carl Rogers that was used in a research study – Studies of Therapeutic Orientation: Ideology and Practice by Nathaniel Raskin (1974). The third segment is from a demonstration interview by Barbara Temaner Brodley with Monika done in Szeged, Hungary, 1986. The fourth segment is from an interview by Usha Surabhi with a client, 1986.
A Client-Centered Psychotherapy Practice

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Chicago

My intent here is to provide a brief description of the principal features of my client-centered psychotherapy practice. My practice has evolved from my attempt to embody Rogers' ideas about helping relationships in my work with clients over many years. In preparing this paper I hope some other client-centered therapists will be stimulated to describe their own practices so we can have discussion of the similarities and differences among us.

I subscribe to Rogers' first principle - the actualizing tendency inherent in persons (1980a). I view this tendency as the sole and original motivating principle in human beings which brings about growth, differentiation, development, self-maintenance and change. I also subscribe to Rogers' theory of the necessary and sufficient conditions of therapeutic personality change (1957). These conditions are the attitudes of congruence, unconditional positive regard and empathic understanding of the client's internal frame of reference. I view the actualizing tendency and these attitudinal conditions to be applicable to all therapeutic relationships with all individuals.

I also subscribe to a set of values which are implicit or explicit in Rogers' theoretical writings: (1) Human nature is intrinsically constructive. (2) Human nature is intrinsically social. (3) Self-regard is a basic human need which, along with autonomy and individual sensitivity, is to be protected in helping relationships. (4) Persons are motivated to perceive realistically and to pursue the truth of situations. (5) Perceptions are a major determinant of personal experience and behavior. Thus, to understand a person one must attempt to understand him/her empathically, from the perspective of his/her own perceptions. (6) The individual person is the basic unit and the one related to in situations intended to foster growth and change. Not groups, not family groups, not organizations, etc. (7) The concept of the "whole

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person" is part of the helper's experience of the person in therapy. (8) In helping relationships, the pursuit of control or authority over other persons is abdicated. Instead, there is a commitment to share power and control. (9) A belief that persons are realizing themselves and protecting themselves as best they can under the internal and external circumstances that exist at the time. (10) In helping relationships, the helper is committed to honesty in relation to him/herself. This honesty is a major means for the helper to maintain and enhance his mental and emotional health and the health of his relationships.

Through the years I have thought about my work with clients a great deal. I made many observations of the effects I was having on my clients. And I tried to determine whether or not I was working consistently with Rogers' theory. I have adjusted my behavior with clients when it seemed inconsistent with the theory and did not seem helpful to my clients. The following discussion is about the main features of the practice that has evolved.

**The Conception of Goals and Implementations**

The principle of an actualizing tendency, the specific theory of the attitudinal conditions for therapeutic change, and the value/assumptions which I have described are active elements in the therapist's mind and feelings throughout the therapy relationship. These elements also function before the specific therapy relationship begins. They influence the conscious, a priori choices that I make about goals and about how they are implemented. Out of my reading of Rogers and out of my experience as therapist I subscribe to the following conceptions which are general and prior to relating to any client.

My a priori goal for my client is to help my client realize his/her own goals. These client goals may be clear from the beginning of the work and may or may not change during the course of our work, or they may be unclear and tentative and evolve and change during the course of our work. Usually these goals involve gaining relief from psychological pain or suffering, making changes in the client's self in ways the client perceives as growthful or more healthful, and making changes in the client's life situations such that the situations are more conducive to the well being and effectiveness of the client and close others. But I never have specific goals in mind for my client not at the
beginning nor at any point in the therapy. I work only from my awareness of the client's goals, although I do not adopt even those.

I do have specific goals for myself that are prior to and apply to all my therapy relationships. I try to provide the interpersonal conditions which I believe are - if experienced by the client - productive of growth, change, health and relief from pain. My immediate and constant goal for myself in the relation with my client is the living and experiencing of the three attitudinal conditions and the living of my respect for the client and his rights in the relationship. I want to be congruent, to be accepting in an unconditional way and to empathically understand my client - all of these to the greatest extent possible, and I want to express these attitudes so the client has the opportunity to experience me as having these attitudes in the relationship. Conscious and unconscious disciplines are involved in realizing these personal goals in relationships with clients. Wanting does not, alone, make it so.

What are my a priori conceptions about the implementation of the ideas and attitudes that have been mentioned? In answering this question I feel I must address my view of what it is that is therapeutic in my client-centered therapy work with clients - that is, what the mechanisms of change involve.

The Mechanisms of Change

I believe the change processes in the client are the result, directly, of the attitudinal conditions being provided and experienced to some significant degree by the client. The mechanism is the process of adoption, by the client, of the attitudinal conditions in him/herself and toward him/herself. The process of adoption of the attitudinal conditions by the client into self frees and enhances the capabilities and energies of the client. This process brings out the client's wisdom about himself and arouses potentialities to be realized more fully in his/her life.

The explorations, understandings, insights, the releases of tensions, the actions the client takes in new ways outside the therapy session and other things that happen in the process of therapy - are the concrete ways the particular client lives in and experiences the attitudinal conditions. These ways are not only stimulated by the therapy relationship, but also are new experiences because they are
occurring in the context of the therapist's attitudinal conditions. The interaction between the client's behavior/experience while in therapy and the client's sense of the attitudinal conditions as context results, I think, in the gradual absorption and adoption of the attitudinal conditions.

Rogers (1984) expressed this idea of the mechanisms of change. He said that he thought the mechanisms basically involve the client taking on the three therapeutic attitudinal conditions in himself and toward himself and others. Looking at the therapy process and its effects over the years, this seems the truest accounting to me. The processes are immensely variable and the ways people feel progress and change appear to be so different from person to person. What stands out as the most constant observable in all that variability is the way in which clients become more congruent, more accepting towards self and others, and more empathic towards themselves and others.

An important implication of this view of what it is that works to make therapeutic change happen is that it does not matter from the perspective of creating change what the client talks about or expresses or whether or not the client talks about his most serious or significant issues. Whatever level of risk or emotional engagement the client offers is that client's concrete participation in the relationship. It is the basis, then, of the client's interaction with me, with the attitudinal conditions being a salient expression of myself in the relationship. The therapist does not need to be concerned or worry about whether or not the client is "getting at" what "he should get at". Thus the therapist is truly freed of concerns that can result in directiveness and judgmentalness.

Returning to the idea of implementations - what, given my above stated conception of the mechanisms of therapeutic change, are my a priori ideas about implementation of the attitudinal conditions and attitude of respect for the client?

The truest theoretical answer is that the implementation of the therapeutic attitudes depends upon the state of the client, the nature of the client's participation, and upon the capabilities and imagination of the therapist. In other words, there is no standard or inevitable way in which the therapeutic conditions are lived out or expressed in client-centered therapy.
There is, however, a very likely way of implementing the attitudes in my work with individual clients, given the type of client I am likely to meet and given my capabilities and imagination.

The clients I see, and have seen for the most part of the past twenty six out of thirty two years of doing therapy, are clients who are able and willing to discuss or explore their concerns, problems and personal experiences. With these clients the form of interaction which seems to me most natural and effective as an implementation of the therapeutic conditions is the empathic understanding response process (Temaner, 1977). This is the way of working illustrated by Carl Rogers in his films, demonstrations and typescripts of therapy sessions.²

I shall discuss this major form of interaction in the next section, but now wish to state a perspective which I would like the reader to keep in mind as he/she reads along. First, the way of working I am discussing and describing as my own is not being put forward as the only way of working that can be based on Carl Rogers' theory. This presentation is intended to communicate the main features of my way of working from Rogers' theory. It may coincide with the way other client-centered therapists work or it may not, although I expect there would be at least overlap between my way and the way of others. Second, I am discussing only individual therapy in this paper. Third, my use of the empathic understanding response process as my major form of implementation with clients who feel a need for help and who are able to talk about their concerns is not meant to imply that this is the only or inevitable implementation of Rogers' theory with such clients.

**The Empathic Understanding Response Process**

The empathic understanding response process is the salient form of my therapeutic work with clients. Within this form there is a unique and spontaneous interaction between myself and each client. There are always great differences in the qualities of interactive expressiveness and the use of language between me and each client. Each relationship is unique and different in many ways. But the form within which all this uniqueness and differences take place does have certain regular or consistent characteristics:
1. The therapist is experiencing congruence and unconditional positive regard in relation to the client and experiencing the intention to empathically understand the client.
2. The client is communicating to the therapist talking and expressing about him/herself.
3. The therapist is able to experience specific empathic understandings of the particular client's internal frame of reference.
4. The therapist attempts, from time to time, to check the correctness of his/her felt understanding by making empathic understanding responses, or by making responses that summarize what the client seems to have been expressing, or by asking questions for clarification of the client's meanings.
5. The client feels understood, feels accepted-(not judged or evaluated) by the therapist, and experiences the therapist as genuine in their relation.
6. The client develops feelings of freedom and personal power in the relation with the therapist, has feelings of safety from punishment by the therapist, has feelings of being stimulated to explore and think more deeply about his/her concerns, and has feelings of affection and attachment to the therapist.
7. The client continues to talk and express and explore his/her problems more deeply and expansively; and the client feels he/she is making progress.
8. As the interaction continues with the qualities described above, the therapist has a strengthened and higher level experience of the therapeutic attitudes and builds a richer empathic experience of the client in his/her own experience/memory.

The empathic understanding response process can be superficially identified or recognized by the salience of empathic understanding responses, summaries and questions for the purpose of clarification by the therapist. And by the appearance of a self-exploratory process in the client's communication. Although it may be difficult to identify with certainty, the empathic understanding response process is only genuine and full of the potency of the genuine process if the therapist is experiencing the therapeutic attitudes at a high level and the client is feeling them.
Other Forms and Kinds of Interaction

The empathic understanding response process has always been the salient and, to me, the most natural and effective implementation of the therapeutic attitudinal conditions. In my early years of doing therapy - perhaps at least the first ten years from 1955 to 1965 - I felt uneasy and uncertain about other forms of interaction with my clients. Although I engaged in these other forms on some occasions.

I answered questions, for example. But I would be very aware of the possible misunderstandings that could come from my answers, and aware of the judgments or values that could be read in my answers. I feared I was violating the atmosphere of acceptance and understanding that I was committed to providing by bringing in, even implicitly and with care not to do so, my ideas and values in answering questions.

I was committed to the therapeutic relation as a genuine person-to-person relation. I did not want to play a role or act as if I had a right, because of my expertise or status, to assert authority over my clients. It seemed, therefore, that I had no alternative, when asked, but to answer any question as honestly and well as I could. But then I felt I might be destroying the feelings of safety and of freedom I was, otherwise, stimulating in my client. It was a dilemma I suffered with for a long time.

The discussion that follows, about other forms, comes out of having resolved my earlier feelings of dilemma. I accepted that there could be other forms of interaction with my clients than empathic understanding response process. And I discovered I could still be faithful to client-centered theory and values.

There are, with many of my clients, sequences of interaction which are interspersed within the empathic understanding response process. They are breaks or intermissions in that process. These breaks may be very brief and/or rare with some clients, while with others one or more of these forms of interaction may be extensive and/or frequent. The forms to which I am referring, here, are: (1) Therapist-presenting in response to client questions. (2) Accommodations requested by clients. (3) Initiation by the therapist of thoughts, feelings or reactions about the client, including (a) responses out of persistent feelings and (b) spontaneous responses.
So far, I have described the empathic understanding response process and indicated that there are these other forms of interaction I engage in when doing therapy. Now, in order to communicate to the reader the nature of these other forms I need to elucidate an attitude that is present in my work which, I believe, is inherent in Rogers' theory. This attitude informs and influences any implementation of the theory of therapy. This attitude is called the "nondirective attitude". 4

The idea of client-centered therapy as "nondirective" has become problematical because some teachers and therapists have made rigid and incorrect interpretations of the element of nondirectiveness in client-centered therapy. 5 I must risk some of the bad associations which now adhere to the idea of "nondirective" because I believe the nondirective attitude is a significant element in Rogers' theory of therapy and in my own work.

The Nondirective Attitude

Nondirective refers to an attitude toward the client and toward therapeutic work with the client. It is an attitude that develops in the therapist from whole-hearted and consistent subscription to the first principle of client-centered theory. The belief in the actualizing tendency and the valuing of and respect for the client stimulate feelings of sensitivity towards the client's directions, interests and self-maintaining processes. But the nondirective attitude does not refer to an avoidance of giving specific direction such as support, information, guidance, answers, etc., to clients. Rather, the nondirective attitude is an inner experience of freedom from assuming what might be good or helpful for clients. It also includes being free of impulses to express one's helping instinct in the form of giving direction or interpretations. This involves an acceptance of the outsider's ignorance and helplessness in finding and effecting solutions to other people's problems. It involves, I think, a quality of humility.

The nondirective attitude also includes being free to provide responses to clients - responses which may appear directive - when they are requested, without feeling a need to justify them by assuming they are helpful. Another way of stating this is to say that the therapist can feel the freedom to be cooperative with the client's experiments that emerge out of what the client thinks or feels might be helpful to him. This is a willingness to share some of the client's risks.
The avoidance of directive responses can be a form of directive attitude in the context of a client's request for such responses. Brink (1987) states this position as follows:

When nondirectiveness is rigidly adhered to as the supreme principle to direct therapist behavior, a doubly reductionistic system results. The complexity of the client is reduced to fit a pre-conceived model that derives from a reduction of Rogers' rich threefold approach to providing a growthful climate for his client. By clinging to the idea of equality-expressed-nondirectively, the therapist creates a reality of unbridgeable inequality by remaining the wielder of a powerful technique, clearly the expert in control of the therapeutic relationship, a professional role rather than a helping person (pp 30-31).

The nondirective attitude expresses the strong emphasis Rogers' theory places on respect for the client as a distinct and unique person who has natural requirements and rights for maintaining his self-regard, self-regulation, self-direction and a feeling of well-being or enhancement in situations.

It is likely to be damaging and disempowering for one to submit (without very good and special reasons) to a situation in which another person is allowed to assume superior knowledge and power over one's own experiences or their meaning. I have come to this conclusion from listening to clients and friends describe their relations with former therapists, physicians, teachers, employers and some parents. Self-regard and confidence in self are vulnerable attributes. The destructive things done by people in these roles of authority are often done out of good intentions. People, including otherwise mature adults, often submit to the authority of these roles. The authority of the therapist, like that of the physician, is especially dangerous because the people served are usually in a personally vulnerable condition. Most therapists, even the avowed humanistic ones, believe they should figure out what is wrong with their client, figure out what strategy (treatment plan) is appropriate for the client, and then carry out the strategy with definite goals in mind for the client. In other words, a directive attitude is rampant in the field of psychotherapy, except, as
far as I can tell, among therapists who try to function consciously from the person-centered perspective or from Rogers' client-centered theory. Many therapists will refuse to answer client's questions, or not even rearrange appointment times, on the grounds that they will be catering to the client's dependence, or succumbing to the client's manipulations, or being complicit in the client's avoidance of significant issues. These interpretations convey to the client that he/she should stay in line, not ask questions, and not initiate things out of their perceived self interest. They have the impact of both control and disapproval.

These interpretations, if swallowed by the client in the context of the client’s having asked a question or having attempted to initiate something, are very likely to undermine the client's appropriate feelings of authority and sense of confidence.

Refusing to answer a question on the basis that it would not be good for the client to be given an answer by the therapist is an example of the therapist’s using the professional role and status in the therapy set-up to exercise control and authority over the client. It is a refusal to cooperate with the client on the basis of the client's sense of what might be helpful or needed by him at that time. This is paternalism - acting on one's own ideas of what might be good for another person without their enlightened consent or against their wishes.

The paternalism of "I, the therapist, know what is best for you, better than you do" is an expression of directive attitude and reflects little faith in the client's capacity to discover his own directions and solutions. The nondirective attitude, in contrast, expresses the feeling that the client is the best expert about himself.\(^6\)

The nondirective attitude also involves the feeling, in the therapist, that he/she has the responsibility while in the therapy relation to be mindful of and protective towards the client's autonomy, self-direction and self-regulation by keeping an eye and a restraint on his/her power in the therapy situation.

The nondirective attitude is a pervasive attitude which influences the expression of the therapeutic attitudinal conditions when they are implemented by empathic understanding response process and when they are implemented by the several other forms of interaction which I shall now discuss.
Responding to Clients’ Questions

I respond directly and acceptingly to questions asked by my clients. In ordinary person-to-person relations, we normally respond to questions according to our inclination or ability to answer. Even if our personal inclination is not to give the information or not to exert the effort to give an answer, our normal courteousness requires acknowledgment of the question and an explanation or an excuse for not answering what was requested.

This ordinary approach to questions is based on the assumption of the freedom of both persons (to ask questions and to answer or to refuse to answer) and the assumption of equality between the persons with concomitant respectfulness towards each other (by answering or accounting for not answering).

I think these same values apply in the therapy relation. Whether or not the response to the client's question turns out to be significant for the client, or helpful in any way, treating questions respectfully (and thereby treating the client respectfully) contributes to the quality of the relationship experienced by the client. It reaffirms the therapist's genuineness as a person and reaffirms the therapist's abstention from power over the client.

There are some things I do to make the question/answer interaction clear between me and my client and which give this form of interaction a more fluid connection to the empathic understanding response process.

First, I engage in empathic process to clarify the question. I want to address the question that is truly being asked and sometimes this requires considerable back and forth clarification between me and my client. Second, while answering the question I try to explicate my methodology and my sources of information in arriving at an answer. I want to share my means to the answer and demystify my answering. Third, after I have presented my answer I check with the client "Did this answer really respond to what you wanted to hear about?" and, also "Do you have any reactions to the answer I've given?". Fourth, the client's responses to these questions are treated as any client communication about himself - with the therapeutic attitudes implemented by empathic process.

These procedures seem to help integrate the question/answer situation with the empathic understanding response process even
though it is a distinct break in empathic process because the therapist is speaking from his/her own frame of reference.

As a consequence of this open, respectful and non-paternalistic attitude toward clients' questions, some sessions or portions of a session may consist of the therapist’s responsive expressions and the subsequent interactions between client and therapist that relate to the therapist’s responses.

Over time, employing the approach to questions as described, I have been surprised, but gratified, to learn from my clients that my way of answering questions has not been experienced as directive nor experienced as a break in my attitudes of acceptance and understanding. It seems that my commitment to, and the consistency of my feeling the therapeutic attitudes, and my feeling nondirective, together with the circumstances of my client asking questions of me, have the effect of transforming what might otherwise be experienced as directive into meanings for that client that are close to or identical with the meanings experienced when we are engaged in empathic process. In other words, I have the impression from my clients that they experience me as consistently congruent, accepting and empathically understanding when I am literally giving information, explaining something, or disclosing something about myself, or, even, giving an opinion concerning them from my own frame of reference!

**Accommodations by the Therapist**

Another expression of the nondirective attitude which results in a form of interaction other than empathic understanding response process is my response to requests for special procedures or accommodations. I am open to making accommodations. I do not require that the client nor I have assurance that the accommodation will be helpful or, even, not harmful. My attitude is experimental and I try to communicate that that is my attitude toward whatever my client has requested, if I agree to participate in it.

Kinds of accommodation which have been asked of me include the following: modifications in the length and frequency of sessions, the arrangements in the therapy room, the use of telephone for sessions, the use of the therapist as a monitor or director, the use of the therapist as an advocate, the use of the therapist as a trainer or instructor, the use of the therapist as a resource, etc.
The break in empathic understanding response process that occurs in responding to requests for accommodation may be minimal or extensive. If the break is a matter of discussing, for example, a modification in the usual pattern of sessions, the break is likely to be minimal. If the accommodation, however, is for a significant modification in the actions I am being asked to employ in interactions with the client (e.g., a request to monitor the client for distractive themes in his conversation and to directively help the client to maintain a more focused presentation) the process of discussing this modification and the process of employing it - both - may make an extensive break in pure empathic understanding response process.

Over the years that I have been accommodating to my clients' requests I have become aware of some criteria that function implicitly to influence whether or not I cooperate. These are: (1) whether or not I have the skills, capabilities, knowledge or expertise at an adequate level, (2) whether or not I have a genuine interest in functioning as the client requests, (3) whether or not my personal and professional circumstances realistically permit the accommodation, (4) that I experience clarity of understanding of the client's request, what it is and what it is for, (5) that I have an open feeling, or if my feeling is reserved, that I am able to be clear about that and share it with the client, (6) in general, that I feel able to be honest with the client in disclosing my feelings about the accommodation or my experience of it as we go along, (7) an experimental attitude about the accommodation, that it can be evaluated and changed if it does not suit either of us.

These criteria have become more conscious and explicit as I react to a client's request for accommodation, over the years. But whether explicit or implicit they constitute a demand on the therapist to know him/herself and his/her feelings well and to experience a high level of congruence in the relationship.

But it is important, I feel, to point out that among my criteria is one about judgment as to whether or not the accommodation is likely to be helpful. If asked for my opinion on this point by my client, I give an opinion if I have one. Of course, if the accommodation was, in my judgment, an unethical or destructive one I would discuss this with the client and probably would not cooperate with it. This point is important because, I believe, it reflects the sharing of control of the therapy with the client and the nondirective attitude.
Therapist Initiation of Thoughts, Feelings and Reactions

The implementation of client-centered values and the therapeutic attitudinal conditions through creating and maintaining empathic understanding response process has, I believe, developmental effects on the therapist. The experience, over a long time, of empathically understanding clients cultivates in the therapist a discipline wherein the therapist loses the temptation to deviate from the process.

The over time effect on the therapist of empathically understanding seems to involve a reinforcement and development of the therapeutic attitudes, respect for the client and the nondirective attitude. I have observed in myself a diminished temptation to be drawn away from empathic attention to my client by ruminations or by speculations about my client. It seems to me that the discipline and practice of empathic understanding gradually influences the consciousness and the desires of the therapist as he/she engages in the process with client after client.

I do not think about, speculate about, worry about or diagnose my clients when I am with them nor during the intervals between sessions. A client may come to my mind, occasionally, outside of a session. And I may have a moment of wondering how someone is doing, given the problem or task they are facing. I also have affectionate images of clients, sometimes, between sessions, but these are momentary. There are occasional exceptions to what I am saying, but they are rare. In general, my relation to clients is almost entirely within the empathic connection, during sessions with them. And my focus is on understanding them empathically during the time we are together.

There are, however, occasions when I initiate responses from my own frame of reference and express them to my client. These responses, obviously, are not empathic understanding responses. They are from my own frame of reference, and they are not responses to requests or questions from my client. They occur in or emerge out of the context of empathic understanding response process.

There are two types of non-empathic responses initiated by me that I have become aware of - responses occurring out of persistent feelings and spontaneous responses.
Responses Out of Persistent Feelings

This category of therapist-initiated responses that issue from the therapist's internal frame of reference are occasioned by the therapist’s experiencing a persistent feeling that is not empathic or not acceptant in the context of empathic understanding response process. The persistent feeling may be beginning to evoke a feeling of incongruence in the relationship from the therapist's point of view.

An example of such a persistent feeling is a situation wherein the therapist is aware of having feelings of irritation or annoyance towards the client, and these same feelings arise occasionally in some sessions. The therapist attends more deeply to these feelings and notices that they arise in reaction to what seems an innuendo in the client's remarks. The therapist realizes he/she has interpreted this perception of an innuendo as covert criticism of the therapist, and this is why he/she is annoyed. But the stimulus is ambiguous, when looked at anew. The client may be feeling and expressing some criticality towards the therapist, or something else may be bringing about the appearance of an innuendo.

I go about responding to such a persistent feeling situation in the following way: (1) I ask the client for permission to discuss something I have been feeling. (2) I explain the feelings in a straightforward but tentative manner. I try to be clear and honest about the feelings, and tentative about my interpretation that the client is expressing critical feelings towards me. (3) I ask the client what he or she feels about my reactions and interpretation. (4) All of the client's responses to my question become the focus of my empathic attention and I orient myself to respond empathically. It depends upon the client's reactions to my disclosures as to what further discussion might ensue.

This category of therapist-initiated responses based on persistent feelings is discussed by Rogers (1980b). The view that the client-centered therapist should feel free to speak out from his/ her own frame of reference in response to persistent feelings is endorsed by Rogers' acknowledgment that this is his own practice. He presents this kind of responding as a corrective for incongruence of the therapist in the relationship when he is experiencing non-empathic or non-acceptant feelings in relation to one's client.
In addition to being a corrective for incongruence, the addressing of persistent feelings is a corrective for not understanding empathically. If the therapist is experiencing the therapeutic attitudes at a high level and in that context, if these other feelings do emerge with some persistence, then there must be something being expressed which is not yet empathically understood.\(^7\)

An important reason, to my mind, for addressing a persistent feeling that is outside the parameters of the empathic is to further understand. I am not making any assumption about its being therapeutic for the client for this problematic experience of the therapist to be explored. It is probably good for the therapist (whether or not it is good for the client) because addressing the persistent feeling is likely to result in clarification for the therapist of the client's feelings and bring the therapist back to the empathic domain in respect to the stimulus situation. By addressing his feelings, the therapist has created the possibility of understanding his own experience in the situation. He/she re-establishes congruence and frees him/herself to return to an undisturbed empathic understanding response interaction.

**Spontaneous Responses**

This category of therapist-initiated responses are made spontaneously (i.e., without being thought through beforehand) about the client, to the client, in the context of the empathic process and they have not been elicited, as the former category is, by persistent feelings. I think this category may be what Rogers refers to in his article (1986), that presents his interview with "Jan", and which he calls "intuitive" responses.\(^8\)

Spontaneous responses seem to happen only in the context of an extended relation with a client. In my case they don't come up in the first or early interviews with a client. They happen when the empathic understanding process has been underway and developing in me a very strong and rich sense of the client's feelings, attitudes, ideas and circumstances.

It is also usually the case, when spontaneous responses occur, that my client has previously asked me some questions, or asked for some accommodation. And I have experienced the client as able to understand me very well and accurately. That is, the client has been able to take in my responses to him - specifically the ones that came
from my frame of reference - as I intended them. Misunderstandings have not developed in my relation with the client.

Distractions from empathic process do not happen very often in my work. When they do I am likely to give the thoughts, feelings or reactions consideration after the session to assess whether or not they may have relevance to my empathic understandings or my relationship with my client. I usually put them aside, in the session, and re-attend to my client. But this category of "spontaneous responses" refers to distractions to which I give utterance, and I do so without much thought beforehand. These responses include evaluative reactions (e.g., "that's awful"), interpretations, integrations of material previously discussed with present material, providing examples from my own imagination or from my memory of material from the client, self-disclosures that serve as illustrations of the client's point, self-disclosures that contrast to the client's point, etc.9

It seems to me that when I have uttered responses that I am categorizing as "spontaneous responses" they have had particular qualities, to me, subjectively. These qualities are as follows. First, the thoughts, feelings or reactions are relevant to the client's agenda of purposes that have been communicated previously or, more likely, the particular session. But they may not be relevant to what the client is immediately expressing. They usually do not, but they may, change the subject. They are not empathic understanding responses, summaries or questions for clarification. They are a distinct break in the empathic process with its close empathic following of the client.

Second, the thoughts, feelings or reactions that become spontaneous responses have, for me, a quality of importance for the client. This is a feeling that the client would be very interested in what has occurred to me. This does not mean I am right about my impressions. I am describing the subjective character of the spontaneous responses as I sometimes experience them as I am voicing them. These responses at least some of them-seem at the time like insights for the client. Third, they usually have the character of spontaneous reactions, not ideas I have been thinking about nor ruminations that I have been experiencing during the session. They seem to come to me all of a sudden in the context of listening and engaging empathically.

Immediately before voicing a spontaneous response I usually tell my client that I have some thought or reaction that might be of
interest to him or her, and I ask permission to voice it. And, after I have expressed whatever it is, I usually ask if I have been clear, ask if there is any question about it, and I ask what the client's reaction to it is at the time. These procedures surrounding a spontaneous response allow the client to orient to taking in something that is not empathic understanding and allow me to find out some of the effects on the client of what I have expressed.

Most of the reactions I have had from clients with whom I have voiced spontaneous responses are supportive about these responses. Clients often express a feeling of appreciation that I have shared my reaction. They seem to feel a reassurance from it that I am open with them.

As far as the usefulness of the spontaneous responses is concerned, that is variable. For the most part, the client either accepts my thought, feeling or reaction as directly helpful in contributing to their self understanding or as directly empathic in attitude, even if it is not immediately relevant to what they had just been expressing. Another response, in respect to usefulness, from my clients has been a kind of differentiating reaction. In these instances the client denied the truth or accuracy of what I expressed about them, but it seemed to stimulate a more exact or truthful self-realization. So, for the most part, my impression with my clients, when I have voiced spontaneous responses, is that they are utilized constructively. And they also seem to contribute to my clients' sense of my realness and my desire to be helpful.

I am being explicit and candid in writing about my "spontaneous responses", but I feel uncomfortable in writing about this kind of response because I fear I might be misunderstood.

I do not want to sound like I am justifying this form of response in client-centered therapy. I don't want to come across as if I am recommending this form of response. I do not mean to recommend it to anyone, even to myself. Whether it will hold up in my practice, or not I don't know. I have been experimenting by allowing it to happen for some time. Spontaneous responses, it should be understood, are not deliberate, not intended. I do not think they can be intended. Intention would make a different phenomenon.

I am uncomfortable about writing of these spontaneous responses because they basically go against my conservative version of client-centeredness in which I place a great emphasis and
dependence upon the empathic understanding response process as implementation of the therapeutic attitudes. But, over a long time, in my work, they have gradually emerged and I have given myself license for them. So much so that I feel they must be listed with the forms of response that occur in my therapy. This is so even though they are still not frequent and occur not at all with some clients.

**Summary**

I hope I have given the reader a sufficiently clear idea of the major features of my client-centered work with individual clients. And I hope I have given some idea of my theoretical rationales for these features. I regret I have not provided examples, other than the few, of the other-than-empathic-process forms of interaction which occur in my practice. I simply have not had time to go over tapes to select examples. This is something I plan to do for a later version of this paper.

The main features of my practice which have been discussed are: (1) My conception of a priori goals and implementations. (2) Emphasis on and salience of the empathic understanding response process as implementation of the therapeutic theory - with clients who feel they have problems and feel they need help and who are able and willing to discuss themselves. (3) Forms of implementation of the therapeutic attitudes which constitute a break in empathic understanding response process. The role of the nondirective attitude is discussed. The forms which are other-than-empathic process are - therapist presenting in response to client questions, therapist accommodations, and therapist-initiated responses of two types - responses to persistent feelings and spontaneous responses. (4) Some conditions for the occurrence of these forms and some procedures surrounding the forms are also discussed.
Endnotes

1. These values are discussed in a paper by J. Bozarth and B.T. Brodley (1986). The tenth value, however, was suggested by Alberto Zucconi.

2. See Appendix A for an illustration of empathic understanding response process in an excerpt from a film of Carl Rogers in a therapy session with "Miss Mun".

3. Empathic responses and client self-exploration are not a sure sign of the presence of empathic understanding response process. It is possible to use empathic responses as a technique and for the client to respond with self-exploration without the basic therapeutic attitudes being present in the therapist. This technique type of process may be helpful, as are many other things therapists may do with their clients.

4. Raskin (1947) discusses the nondirective attitude as well as in his paper, "The development of nondirective therapy" (1948).

5. This is discussed eloquently by Brink (1987).

6. The belief that the client is the best expert about himself is not a naive and blind optimism that denies people can make terrible mistakes about themselves. It is an optimistic view, but based on many observations that - under conditions of freedom, safety and understanding people take responsibility, perceive clearly, utilize their information well, and learn from experience, with the result that they make better and better choices. The individual person has, potentially, the most total access to self that is possible, through consciousness and processes of thought and feeling. This amalgam under therapeutic conditions tends to result in an amazing and effective expertise.

7. In the context of empathic understanding, responses of annoyance or disturbance in relation to clients simply do not occur, even if the material coming from the client would, from my own frame of reference, stimulate annoyance or disturbance. Therefore, the persistent feelings that are annoyance or disturbance signal, to me, a lapse in, or incomplete, empathic understanding.
8. I am not referring to these responses as "intuitive" because the word implies that the responses have validity or correctness for the client and because the term implies knowledge not grasped through perception and reasoning.

9. See Appendix B for an example of a spontaneous response from a fortieth session with a young woman who suffers from a chronic physical illness.

Appendix A

C29: I was thinking the other night, I was feeling very blue about the way I felt, and I thought, well... maybe, I wish I had my mother here in the way that she was, because she used to be... sort of reassuring when I was ill and she would do little things, and make some special dish, like custard or something. It was sort of reassuring sort of to have her around. (T: Mhm) And, of course, I know that she isn't able to be that way any longer. I don't know what it all means, but for a minute I thought I really miss her. I sort of need a mother at this point and yet that's sort of impossible...

T29: But even though it's factually impossible, the feeling was... 'Gee, I miss her, I wish she was here to take care of me and look after me'. (C: Mhm)... (19 sec. pause)

C30: And yet at the same time I felt, well - a little later, so - I thought that... maybe that wasn't what I needed, maybe it was a more adult... sort of... companionship or something in some way, rather than a mother. But I needed something or somebody...

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ii In the course of many years, Barbara transcribed and supervised others in transcribing Rogers’ therapy and demonstration sessions. The transcript work culminated in a joint effort with Germain Lietaer resulting in a journal article (Lietaer & Brodley, 2003) and an informal email publication (Brodley & Lietaer, 2006). We have replaced the therapy segment by Rogers that Barbara originally included here with the more polished 2006 version.
T30: You really didn't feel sure in yourself whether... what you wanted was someone to really... give you close mothering... or whether you wanted some more... grown up kind of relationship...

C31: And then, in another sense, I thought, well... maybe it's just something I have to go through alone.

T31: Maybe it's just hopeless to wish that I could really be in a relationship with anybody... Maybe I have to be alone.

C32: The thing that sort of has thrown me this week is that... well, I feel better about the physical condition I talked of last week, and I sort of made friends with my doctor which makes me feel a little better, as though we're not going to be quietly fighting without saying anything. And I think that I have more confidence in my medicine. I read an article about this and it said it's very hard to diagnose, so I don't hold that against him. But he feels he has to be sure, sort of... (words lost) giving me X rays and I'm frightened because I kind of feel that they're trying to be sure it isn't cancer. That really frightens me terribly (T: Mhm), and.... I think it's when I let that... thought come to me, maybe it is and what if it is and... that's when I felt so dreadfully alone.

T32: HmHm... You feel if it's really something like that... then you just feel so alone. (8 sec. pause)

C33: And it's really a frightening kind of loneliness because I don't know who could be with you... and it seems rather. (7 sec. pause)

T33: Is this what you're saying? 'Could... could anyone be with you in... in fear, or in a loneliness like that'? (Client weeps) (30 sec. pause) Just really cuts so deep. (C shakes her head) (13 sec. pause)

C34: I don't know what it would feel like if there were somebody around that I... could feel sort of... as though I did have someone to lean on, in a sense... I don't know whether it would make me
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feel better or not. I was trying to think, well, it's just something that you have to grow within yourself... Just sort of stand... even just the thought of it, I mean, it'll be two weeks, I suppose, before they know. Would it help to have somebody else around, or is it just something you just have to... really be intensely alone in? And that's the... well, I just felt that way this week, so dreadfully, dreadfully, all by myself sort of thing. (T: Mhm)...

T34: Just a feeling as though you're so terribly alone... in the universe, almost, and whether... (C: Uh-hum) whether it even - whether anyone could help - whether it would help if you did have someone to lean on or not, you don't know. (15 sec. pause)

C35: I guess probably basically, that'd be a part of it you would have to do alone. I mean, you, just couldn't take anybody else along in some of the feelings; and yet, it would be sort of a comfort, I guess, not to be alone.

T35: It surely would be nice if you could take someone with you a good deal of the way into your... feelings of aloneness and fear. (14 sec. pause)

C36: I guess I just have. (20 sec. pause)

T36: Maybe that's what you're feeling right this minute. (19 sec. pause)

C37: And I think it is a comfort. (Long pause - 1 min. 27 sec.) And I guess the feeling I have now is, well, I'm probably looking on the very blackest part of it. And maybe there's no real need for that... I mean I... It may just take time to reassure me. (5 sec. pause) And then this will all be sort of unimportant (mhm), although it's something I shan't forget, I'm sure (laughs) (T: mhm)...

Appendix B

C: I do this...I think about that kind of stuff all the time... And I sit there and go..."why do you do this?", "why do you even think about this stuff?"

T: That you have such intricate motives...(C: yeah)...and you wonder why you think of yourself that way. (C: nodding)... Uh um.

C: It's a vicious cycle.

T: ...I have a guess...would you be interested...? (C: nods) This is a speculation as to how this kind of suspicion of yourself developed...the question is... why do you have the suspicion of yourself? (C: Right) What I am speculating is...that here you had an illness that was out of your control...That's a fact...And you had pain ...and different discomforts...and it was dangerous for you. (C: nods) And what is a natural human feeling under these circumstances?...It's wanting to have control... And so, you started scrutinizing yourself and the events and almost wishing that...

C: I see what you're saying.

T: To feel like you could have some control instead of just being this person who is a victim.

C: I understand...That makes sense.

T: ...Do you think that might...(C: Yeah, because it's like...) be the origin, how it got generated?...You weren't trying to do anything to yourself, you were (C: Right) trying to get control and so reading them...

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iii From a fortieth session with a young woman who suffers from a chronic physical illness.
C: So, underneath it all, the bottom line would be...yeah... I'm attributing powers to myself because at least that would mean I had control over it. (T: Uh-um)...I can see what you mean...(T: Uh um) Yeah...that sounds more like me, like the me I really know and trust. (pause)...I'm sitting here thinking about all this stuff I just realized. (T: Yeah) ...(C: laughs)...I was feeling that before...for awhile I've been feeling ...growth. But I still have that vulnerability in me...But deep down I know I'm going to be OK. There's something deep down I just...

T: Something's taken hold, some greater trust in yourself? (C: Uh-um) Another level? (C: Yeah).
References


Brodley, B.T., & Lietaer, G. (2006). *Transcripts of Carl Rogers’ Therapy Sessions, Vols.1–17*. Available from germain.lietaer@psy.kuleuven.be and kmoon1@alumni.uchicago.edu


Some Differences in Clients’ Questions and Rogers’ Responses to Questions Between the Mr. Bryan Sessions and Rogers’ Post-Bryan Therapy Sessions

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Abstract
This paper will present and discuss some of the results from Claudia Kemp’s Doctoral Dissertation research on Carl Rogers’ responses to his clients’ questions. It focuses on the part of Claudia’s study that compares Mr. Bryan’s questions and Rogers’ responses (to those questions) with clients’ questions and Rogers’ responses in a large sample of transcripts made from his later therapy sessions. It reveals some of the ways Rogers was in transition towards becoming a client-centered therapist when conducting the Bryan sessions, and discusses behavioral differences in the two stages of his development – Bryan and post-Bryan.

Introduction

It is not generally recognized that Rogers’ (1942) publication of the full therapy with Mr. Bryan, illustrating ‘non-directive therapy’, does not illustrate the non-directive client-centered therapy that Rogers had developed by the time of its publication and that he continued to practice with only slight modifications until his death.

1 Editor’s Note: This paper was originally edited by Katheryn Moon, Chicago, Illinois, and by Sandy Green at PCCS Books. Subsequent editing was done by Jerome Wilczynski, editor of the PCJ. Thanks to Rollen Cooper for assisting with incorporating the tables into the article.
The published eight-session therapy in *Counseling and Psychotherapy* (Rogers, 1942) illustrates how Rogers was in transition towards client-centered therapy but not yet quite there. By the time the Bryan sessions were published, Rogers appears to have developed further as a client-centered therapist than during the period one to three years earlier (1939 to 1941—the exact date is unknown) when he conducted the Bryan sessions. This development is suggested by his extensive critique of his responses to Mr. Bryan in the 1942 publication.

Rogers’ critique, written from his non-directive perspective and footnoted to the Bryan transcription, identified many mistakes in his therapy behavior with Mr. Bryan. The footnotes reveal that at the time of writing his critiques, Rogers’ *consciousness* of the behavior implied by his theory was more advanced than his earlier actual behavior with Mr. Bryan. It is also apparent, judging from the almost complete absence of guidance-type remarks (e.g., evaluations and suggestions) in Bryan, and from his infrequent interpretive-type remarks, that Rogers’ work with Mr. Bryan was in transition toward client-centered therapy, moving away from his earlier form of therapy (Rogers, 1939, 1940).

An earlier study (Brodley, 1994/2011) showed that Rogers, working with Mr. Bryan, had not arrived as a fully functional client-centered therapist. On theoretical grounds the earlier study excluded all of Rogers’ responses that followed clients’ questions. That study compared the frequency of Rogers’ empathic responses with his unelicited responses representing the therapist’s frame of reference (T-frame responses). It revealed a large difference (35%) in frequency between Rogers’ unelicited T-frame responses to Mr. Bryan (approximately 45% of all responses), compared to his T-frame responses to clients post-Bryan (approximately 10% of all responses) (Brodley, 1994/2011).

In regard to the data of the current study, found within Kemp (2004), a comparison of clients’ questions and Rogers’ responses to those questions in the two periods of his therapy (Bryan and post-Bryan) should show some (but not all) of the ways Rogers’ therapy changed as he shifted to client-centered therapy. As we’ll see, there are differences between both Mr. Bryan’s questions and Rogers’ replies to questions comparing the two samples.
The Study

Kemp’s (2004) research focused only on clients’ questions and Rogers’ responses to his clients’ questions, excluding from her study all of Rogers’ responses that did not follow immediately from his clients’ questions.

The Questions

To keep our report in perspective for the reader, it is important to point out that Kemp (2004) reports the total number of questions (382 in the two samples) asked of Rogers occurs in a quite small percentage of his clients’ statements. We estimate that a question of any type was asked of Rogers in only 5% of all the (approximate) 7,260 clients’ statements examined in Kemp’s (2004) study. Stated another way, clients asked questions only five times in every 100 of their statements (and some clients’ statements are very long). We conclude that Rogers’ clients did not choose to question him very often compared to the dominance (95% of all responses in both samples) of their behavior in which they narrated about their own concerns and feelings. There are no client questions whatsoever in many transcripts (see Kemp, 2004).

Nevertheless, while keeping the perspective of their infrequency, the kinds of questions clients did ask, and what kinds of response Rogers made to them, as well as differences in Rogers’ replies with Bryan and post-Bryan, can clarify our understanding of Rogers’ development as a client-centered therapist.

The Data

The basic data of the questions aspect of Kemp’s (2004) study are (1) the 67 questions (the Bryan sample) asked by that one client, addressed to Rogers in their eight-session therapy, and (2) the 315 questions (the post-Bryan sample) asked by those later clients in 121 sessions.

It turns out that there is a striking difference in the percentage of clients’ questions (relative to their separate total number of statements) in the two samples. Mr. Bryan addressed questions to Rogers in 14% of his total statements in eight sessions, while post-
Bryan clients addressed questions to him in only 4% of their total statements in 121 sessions (Kemp, 2004). This 10% difference is most likely due, in part, to Mr. Bryan’s character. His statements revealed a strong intellectual orientation to his self-understanding (see Kemp, 2004; probably influenced by the prevalence of psychoanalytic ideas and writings about therapy in the late 1930s), as well as his academic interests.

Of course, many of the clients in the post-Bryan sample were also intellectually and academically oriented (see Kemp, 2004). Some were students or faculty at the University of Chicago, where the Counseling Center was located and where research was conducted using many of the transcripts studied in this sample. It seems likely that the greater percentage of questions asked by Mr. Bryan was partly due to the character of the interaction with Rogers – who in those earlier sessions was engaging in discussions with Mr. Bryan, not only trying to empathically understand him. As we shall see, more of the findings in Kemp’s (2004) study tend to support this hypothesis.

**The Method**

Together, the writers developed a system of classifying each of the client’s questions into one of eleven categories. These question-categories are as follows:

1. Asking the therapist if he understood the client
2. Asking ‘housekeeping’ questions (e.g., appointment times) and about external issues (e.g., about the taping)
3. Asking for information about the workings or theory of psychotherapy
4. Asking for guidance pertaining to the client’s life or subjective experiences, feelings, etc.
5. Asking for guidance pertaining to the client’s actions in therapy
6. Asking for the therapist’s reassurance
7. Asking for an opinion, evaluation, or perspective
8. Asking for permission
9. Asking for personal information about the therapist
10. Asking about the therapist’s recall or observation of the client
11. Asking the therapist to clarify his previous statement
Our individual classifications of questions were made while Claudia and I sat together, and we resolved our differences through discussions (Kemp, 2004).

**Comparisons**

First we compare the frequencies in the two samples of different categories of question and discuss the implications of the differences between Mr. Bryan’s questions and the later clients’ questions (see Table 1). We observe that the most striking difference, as reported by Kemp (2004), is in questions classified as ‘Asking the therapist to clarify his previous statement’ (question 11) – a difference of 21% between the two samples, with 25% of Mr. Bryan’s questions classified as of this type compared with 4% of the later clients’ questions. Although one might speculate that the large difference reflects Mr. Bryan’s personal inclination to raise this particular question, another explanation is more likely to account for the difference.

Recall from the earlier study mentioned above (Brodley, 1994/2011) that approximately 45% of Rogers’ responses to Mr. Bryan were T-frame responses that were spontaneous responses, not elicited by questions, compared with approximately 10% of that type of Rogers’ response post-Bryan. In fact, some of the transcripts of the post-Bryan therapy sessions contained no unelicited T-frame responses by Rogers, only empathic following responses. In his therapy with Mr. Bryan, Rogers was choosing to spontaneously express his own point of view much more frequently than with any client in the post-Bryan sample (Brodley, 1994/2011).

In the context of this earlier observation, it seems reasonable to infer that the substantial difference in frequency of the eleventh question – with Mr. Bryan asking Rogers for clarification about what he had communicated much more often than the post-Bryan clients – is the result of Rogers making a greater demand on Mr. Bryan to understand him than Rogers made on the post-Bryan clients.

Accurate empathic understanding responses are generally easier to understand, in any context, than statements expressing the frame of reference of the speaker. This is even more likely in the context of psychotherapy. The client’s mental processing of T-frame responses is more intellectually demanding on a client than decoding.
Some Differences in Clients’ Questions…

statements made by a therapist who is trying only to represent his empathic understanding of the client. In addition, the content of T-frame responses is sometimes experienced as threatening to the client, stimulating diminished attention or confusion.

Mr. Bryan asked Rogers to clarify his previous statements more frequently than the later clients, most likely because Rogers was more frequently expressing his own thoughts to Mr. Bryan and, consequently, was less easily understood by Mr. Bryan than by the post-Bryan clients who received, predominantly, empathic understanding responses. In addition, the therapy with Mr. Bryan tended to emphasize Rogers as a psychological expert because he was introducing his own thoughts in his unelicited T-frame communications. Consequently Mr. Bryan was probably (although inadvertently) directed to be concerned about accurately understanding Rogers.5

The class of questions showing the second greatest difference between Mr. Bryan and the post-Bryan sample is ‘Asking the therapist if he understood the client’ (question 1; see Table 1). In this case there was a 9% difference, with the post-Bryan clients asking this in 12% of their questions while Mr. Bryan asked this in 3% of his questions to Rogers (Kemp, 2004).

Although it is reasonable to assume that Mr. Bryan wanted Rogers to understand him, the difference in the two samples is probably due to the fact that Rogers’ consistent and highly frequent empathic responses with the post-Bryan clients tended to focus their attention on the therapist’s main goal in client-centered therapy – to empathically understand the client and not introduce the therapist’s thoughts into the therapeutic conversation (Kemp, 2004). Therapist behavior expressing communications representing his or her frame of reference may focus the client’s attention on understanding the therapist. In contrast, Rogers’ pursuit of understanding of a client’s frame of reference, by making empathic understanding responses, promotes further explication by the client and orients the client to care whether he or she is understandable and whether Rogers is following.

Consequently, when Rogers made more frequent T-frame responses and relatively fewer empathic responses to Mr. Bryan, Mr. Bryan was less attuned to whether or not he was being understood by Rogers than the post-Bryan clients who were being consistently empathically understood. The post-Bryan clients received
predominately empathic responses from Rogers and consequently were more attuned to becoming sure he understands them (Brodley 1994/2011).

The remaining differences found in the eleven question categories asked of Rogers between the two samples in Kemp (2004) are very small. They range from a difference of 5% for question 4, ‘Asking for guidance pertaining to the client’s life or subjective experiences, feelings, etc.’ (greater in the post-Bryan sample) to a difference of 0.1% for question 6 ‘Asking for reassurance’ (also greater in the post-Bryan sample) (Kemp, 2004).

A special issue in the question data concerns the frequency of the questions that are likely to be most difficult for a client-centered therapist. In regard to this issue, questions 4 through 8 are all questions that, if answered directly, risk influencing or directing the client. They, more than the other types of question, challenge a client-centered therapist to maintain the nondirective attitude while responding respectfully to the client’s voice (Grant, 1990).

Combining the five questions 4 through 8 for both samples shows 61% of all questions in the two samples to be of the kind that are challenging to a client-centered therapist in regard to expressing his non-directive attitude (Kemp, 2004).

Among the eleven categories of question asked by all clients in the two samples delineated by Kemp (2004), the five kinds of question (together called the ‘challenging’ group) that make greatest demand on the therapist’s skill in communicating the non-directive attitude total slightly more than half of the questions asked.

This finding can be more informatively expressed as – more than half of the questions asked (61%) appear in only 14% of the kinds of questions (see Table 1, questions 4 through 8 combined into one category; data from Kemp, 2004). This is probably due to the fact that clients in therapy are seeking personal changes and consequently, if they are inclined to ask questions, they are most likely to be asking for some form of guidance or direction from the therapist.

Small as the differences are between question-categories 4 through 8, the frequencies of these questions are all greater in the post-Bryan sample, thus permitting their simple addition and comparison by sample. Combining the frequencies of questions 4 through 8 results in 54% of Mr. Bryan’s questions falling into those combined categories, and 63% of the post-Bryan’s clients’ questions – a difference of 9%
with the post-Bryan clients having the greater frequency (see Table 1; data from Kemp, 2004). It may be that although it happens infrequently, clients asked for Rogers’ guidance or direction somewhat more (in percentage of the categories of questions) in the post-Bryan sample because Rogers was not volunteering his point of view or opinions to clients in that sample.

It must be recalled, however, that all together, in both samples in Kemp (2004), clients did not frequently ask questions of Rogers and the statistics comparing questions in the two samples must be placed in that context for a correct and reserved appreciation of their meaning.

**Rogers’ Responses**

To compare the samples, we also developed categories for classifying Rogers’ responses to clients’ questions. These response-categories are as follows:

1. Direct verbal answer to the question
2. Direct nonverbal or vocal gesture answer to the question
3. Indirect answer to the question
4. An empathic understanding, following type of response that addresses or acknowledges the question
5. An empathic understanding, following type of response which does not address or acknowledge the question
6. A response that addresses or acknowledges the question, but is not an empathic understanding type of response
7. A response that does not address or acknowledge and does not answer the client’s question
8. A response that was too ambiguous to be classified (Kemp, 2004)

Sometimes Rogers made a complex response to a question that involved more than one category of response. For example, Rogers sometimes answered a client directly and followed his answer with an empathic understanding response. Some responses to some questions had to be given more than one kind of classification, so Rogers made more responses than the number of questions asked by his clients (see Kemp, 2004).

Kemp (2004) found that Rogers made 465 responses to the 382 total questions in the combined samples. She also found that Rogers made 81 responses to Mr. Bryan’s 67 questions, and made 384
responses to the post-Bryan clients’ 315 questions. In order to make
the most meaningful comparisons, we omit 23 responses (3 in Bryan
and 21 in post-Bryan) that were classified as ‘A response that was too
ambiguous to be classified’ (category 8). Thus Kemp’s sample of
responses consists of a total of 442 responses; 78 are found in the
Bryan transcripts and 364 in the post-Bryan sample (see Table 2; data
from Kemp, 2004).

**Rogers’ Responses in the Two Samples**

Rogers *answered* his clients’ questions much of the time. In
relation to the total sample (Bryan plus post-Bryan) of 382 questions,
46% of Rogers’ responses include direct verbal answers to the
questions. Fifty-five percent of his responses consist of direct verbal
answers combined with nonverbal direct answers and indirect answers.
In effect, Rogers gave an answer-type of response to approximately
half of his clients’ questions. The idea that non-directive, client-
centered therapists do not answer their clients’ questions is a myth
(Kemp, 2004), if we consider Rogers as an exemplar or model of the
approach.

But there are noteworthy differences in his responses to
questions by Mr. Bryan and to those of the post-Bryan clients. First, in
the Bryan sample, Rogers made the majority of his responses (55% of
all his responses to Bryan’s questions) in the category ‘Direct answer’
(category 1). This category includes verbal answers that are simple
‘yes’ or ‘no’ responses and more complex answers. In the post-Bryan
sample, Rogers responded with direct answers to his clients’ questions
less frequently (34% of all his responses) – a difference of 21%. We
find the difference between the samples is the same when nonverbal
direct answers (category 2) are combined with direct verbal answers
(category 1) (Kemp, 2004).

Combining the first three categories of responses (answers to
questions) and comparing Rogers’ frequencies of response in the two
samples shows a 26% difference in Rogers’ behavior in the two
samples (70% in the Bryan sample and 44% in the post-Bryan
sample). In other words, Rogers chose to answer Mr. Bryan’s
questions much more often than, at a later time, he chose to answer the
post-Bryan clients. This difference appears to have resulted from
Rogers’ substantial shift to empathic responses with the post-Bryan clients (Kemp, 2004).

Rogers responded with an empathic understanding response to Mr. Bryan in 14% of his total responses to that client’s questions, whereas he responded to the post-Bryan clients’ questions with an empathic understanding response in 40% of his total responses, a difference of 26% (Kemp, 2004). Informative discussion of this comparison depends upon the perspective of theory as well as a perspective based on what research has shown from comparing Rogers’ responses to Mr. Bryan with his responses to the post-Bryan clients when the clients are spontaneously narrating about themselves.

**Theoretical Discussion**

People typically expect that a question will evoke an answer or at least an acknowledgement of the question as a question. But in client-centered therapy the non-directive principle requires other considerations. On the one hand, in this therapy, all responses should imply respect for the client, respect for the client’s autonomy, respect for the client’s self-determination, and respect for the client’s sense of self. Thus, questions clients ask of the therapist require forms of response that show the therapist’s respect for the client the same as they show in their empathic understanding responses. This ubiquitous respectful attitude is partly expressed in the therapist’s respect for the client’s ‘voice’ (Grant, 1986). In the case of clients’ questions, the client’s ‘voice’ is addressing the therapist for something from the therapist’s point of view, and it would seem that an answer would be appropriate.

On the other hand, it is also part of the non-directive principle of client-centered theory that the therapist maintains the non-directive attitude in his or her relation to clients. An implication of this principle is that the therapist be free of motives to influence clients towards any particular interaction process or towards any particular area of content or towards any personal conclusions. This non-directive principle holds in the question-to-therapist situation, although the situation is different from clients spontaneously narrating to the therapist. In that situation, a respectful form of response that both expresses the basic therapeutic attitudes and tends to avoid influences is usually achieved by following the client with empathic understanding responses. The
therapist intends these responses to check the accuracy of his or her tentative understanding of the client. They are functional and theoretically consistent.

Non-directivity in the context of questions precludes a systematic avoidance or ignoring of clients’ questions and supports responsiveness to questions as questions and giving answers. But the non-directive principle also makes the therapist wary of giving answers. Consequently, the therapist has a choice when it comes to clients’ questions.

A therapist’s fidelity to client-centered principles cannot be evaluated by single responses, because client-centered therapy is a spontaneous process of interaction, with inevitable errors in understanding and necessary corrective processes. A therapist’s fidelity to the theory involves the multitude of ways the therapist expresses the therapeutic attitudes, including the non-directive attitude. Thus when a client asks the therapist a question, the therapist may directly answer, or he (or she) may ignore the question and respond empathically to the client’s narration that is context for the question, or he may acknowledge the question but not answer it—perhaps addressing the question, for example, by giving the client an explanation for not answering—or giving some combination of an acknowledgment or answer and an empathic response. In all of these specific forms of response to a question, the therapist’s attitudes are conveyed by syntax, tone of voice, nonverbal gestures—all permeated with sensitivity to the unique client, to the empathic material of the moment, and expressed with tentativeness and openness to the client as the person determining the directions of the therapy.

When clients are narrating about themselves, client-centered therapists’ empathic responses are not systematic, although they tend to be frequent. This apparent contradiction is because the causes in the therapist for responses flow from theoretically determined experiences of certain attitudes. In the client-question situation, the client-centered therapist also cannot systematically employ any form of response. The therapist must make a choice about how to respond in each particular occasion in order to, overall, maintain his communications as acceptant, empathic, and non-directive.

The client-centered basic theory (Rogers, 1957/1987, 1959) instructs the therapist to experience empathic understanding of the client’s internal frame of reference, imbued with an attitude of
acceptance towards clients. The implication of the theory is that, whenever the therapist responds to clients, whether the clients are narrating about themselves or asking questions of the therapist, whatever form of response (category, in this study) the therapist chooses, it should express the therapeutic attitudes as well as minimize any directive effect on the client.

Summary

The most characteristic form of response in client-centered therapy when clients are narrating about themselves—the empathic understanding response—appeared in only one-seventh of Rogers’ responses to Bryan when he was responding to Bryan’s questions. In contrast the empathic understanding response approached half of Rogers’ responses to his post-Bryan clients, although some of the empathic understanding responses were made in combination with direct answers (Kemp, 2004).

Rogers was giving answers to one-third of his post-Bryan clients’ questions. He was responding only slightly more frequently to them with empathic responses (37%) (Kemp, 2004).

Rogers was not directly answering as frequently to the post-Bryan clients as to Mr. Bryan, but he was making many more empathic responses (combining categories 4 and 5) to these later clients (40% of all his responses) than he made to Mr. Bryan (14%)—a difference of 26%. Rogers directly answered his post-Bryan clients (38% of his responses) almost as frequently as he empathically responded to them (40% of his responses) (Kemp, 2004).
References


Endnotes

1. A combination of guidance techniques and psychoanalytic interpretive therapy (Rogers, 1939, 1940)

2. The study distinguished Rogers’ spontaneous, not-elicited therapist-frame statements from his empathic, following type of responses that are an attempt to represent the client’s internal frame of reference.

3. In client-centered therapy, empathic responses usually satisfy the requirements of theory – non-directivity, therapist congruence, and acceptant, empathic understanding – when the therapist is responding to self-explicating clients. However, when a client addresses the therapist with a question, the therapist’s non-directive attitude requires respect for the client’s ‘voice’, and the therapist must make choices among empathic responses, answering the question, or addressing the question in a way that does not systematically disregard the question as a question. Consequently, research to accurately comprehend client-centered therapy must distinguish between the therapist’s responses that are responses to questions and those that follow the client’s self-explicating narration.

4. This estimate used a mean of 60 client statements (clients’ statements that occur between Rogers’ statements) per session times 129 transcripts studied.

5. Although Rogers spontaneously introduces his own perspectives more frequently with Mr. Bryan than with his post-Bryan clients, the content of his remarks and the manner of his expression do not suggest that Rogers is intending to emphasize his expertise or to direct the client.

6. Client-centered clients change in their sense of self – self-image, self-acceptance, self-expectations, but at all points in the therapeutic interaction, client-centered therapists try to be sensitive to their clients’ present sense of self and do not intend to challenge, criticize, or correct it.

7. These are Rogers’ basic therapeutic attitudes that the therapist holistically experiences as congruence, unconditional positive regard, and empathic understanding of the client’s internal frame of reference.
Table 1: Question Type Frequencies of Bryan Transition Phase (BTP) and Client-Centered Therapy Phase (CCTP)

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Some Differences in Clients’ Questions… 101

Table 2: Response Type Frequencies of Bryan Transition Phase (BTP) and Client-Centered Therapy Phase (CCTP)

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An Interview with Barbara Temaner Brodley About Client-Centered Supervision

Daniel Metevier
Illinois School of Professional Psychology at Argosy University, Chicago

Interview #1

DM: To start, I would be interested in hearing about how you approach clinical supervision.

#1: It depends on the setting of course. If I have the freedom, I don’t consider it supervision, I consider it consultation and that’s theoretically based. That is, I really don’t think one could supervise a therapist who is on the spot with the client and also I don’t think that it’s good for therapists to feel they’re being evaluated all the time and supervision has that connotation. However, if it’s supervision there may be certain things I have to check out, that are administratively required.

DM: You have certain responsibilities?

#1: Yeah, there may be something of the sort, and if there is, then I deal with that in a straightforward way. But that’s understood between the supervisee and me, and then I do whatever I need to do in order to meet that expectation in as considerate a way as possible with the student or the person coming to me or assigned to me. First of all, I assume the person wants to, or is willing to get from me a client-centered perspective on their work. I really don’t want to provide, even if on a purely intellectual way I could, provide something along other lines. I just don’t want to do that, so I have to be in a situation and have people coming to me who have some minimal interest in getting the client-centered perspective on their work and getting help of that kind.

1 This interview with Barbara Brodley is found within: Metevier, D. J. (2002). On client-centered supervision: Its attitudes, processes and dilemmas (Unpublished clinical research project). Illinois School of Professional Psychology, Chicago, IL (see Appendix E).
DM: So that’s like a condition in a way?

#1: Yes, it’s a condition for me. I think that I have the most to offer that way and I’m really not interested in fostering other approaches, so it depends on whether the person feels they can benefit. Although, I’ve never been in a situation where that wasn’t an acceptable understanding. The problem has come up that the person, though willing, was so uninformed about client-centered, and working out of such a different set of premises and using techniques that are not consistent, that it becomes difficult, because what I have to offer in that situation can be so easily perceived as being critical of them and I feel that’s not helping them. So, that is a possible problem. If the person is at a very elementary level, but who is trying to get it, that’s to really learn how to function as a client-centered therapist, then there could be a problem too, because out of just not knowing they may have misconceptions or what have you, so then I feel that I would need to correct them more, inform them, and that’s risky in terms of the person feeling that they’re not doing acceptable work.

DM: They would feel judged.

#1: Feel judged and so on. But in general, if a person is motivated, then the way I work is, -- there are really three things. One is, I do like to hear an example of the person’s work on tape, and I prefer that with a transcript, because it’s just easier for me, and in general, I think making transcripts once in a while is a useful thing for a person learning to do. It gives you a closer scrutiny of what you’re doing. I would ask people to bring in maybe just a segment, it doesn’t have to be a complete tape. Some people want to be more listened to and sometimes a whole session or more of consultation has been listening to tape, and sometimes of course, I do it without the transcript. I’m not rigid, but I strongly prefer the transcript along with the sound. So, that was one thing because I do like to have a direct access to the voice and the manner of the therapist in their work. Obviously, when you’re supervising or consulting, you’re far from getting a complete sample of what people do.

DM: You can’t really get the real experience.
#1: No. Well, you can’t get the range, and people differ. Some people really want to bring in something they consider problematic. Other people feel too vulnerable and they prefer to bring in something they think is good. In any case, it’s useful to me, to get a sense of how the person is functioning. I’m interested to know what their level of capability is in empathic understanding and a sense of their presence, which is their tone and manner, insofar as you can judge that from sound as well as the words and the wording of responses. Because my whole attitude toward the consultation is, does the person, -- has the person grasped the attitudes. So one thing are the tapes to listen to, another is the person talking about a case, talking about a client and talking about the way they work with them, any problems they may have. It’s very much up to the trainee, except at some point I want to hear a tape. If it’s an ongoing supervision thing, then I ask them kind of as soon as they can to bring that in.

DM: You mentioned, if I can roll back just minute, that, -- Is this right, that your purpose is to see to what extent the person has grasped the attitudes or has been able to provide them, --

#1: Yes. Both how well do they understand them and how well do they manifest them. So I was saying there are three things. One is the tapes, the second thing is the person volunteering a dialogue with me about their work with client or clients, and that’s very frequently the way it goes. The third is my giving literally instruction, explaining theoretically or explaining how they might meet a situation. People will ask me, what should I do, should I call the client, should I be telling them about this response that I have that’s inconsistent with the attitudes, whatever. My approach is really across the board, -- My approach to teaching is to try to represent the therapeutic attitudes, not only congruence, unconditional positive regard, and empathic understanding, but the non-directive attitude, responsiveness, the protection of the client’s self determination, the protection of the client’s sense of self. I feel that there are an array of attitudes. If you’re talking about client-centered therapy, not the universal or the generic theory, which is the necessary and sufficient conditions, -- If you’re talking about client-centered therapy, you need to talk about more than the basic attitudes, even though they’re central, and so what I tend to do if I’m being asked or I decide that I think it would be the best thing
in the situation to, in a way instruct the person, is I review the attitudes that they’re trying to manifest in the situation and then review the nature of the situation and then the task is to figure out how these attitudes can be most fully realized in that situation. In general, I think the approach should be to work from the attitudes, not from technique or solving, -- in a way you’re solving a problem, but the questions you ask yourself, I think, from a client-centered perspective are - there are these attitudes that I want to manifest as much as possible, how can I do that in this situation, and obviously I’m referring primarily now to situations where for some reason empathic following does not seem to be the answer or isn’t a sufficient answer to meet the situation.

DM: So maybe the consultee has found that they’ve attempted to do that and something has come up that they need, --

#1: Yeah, the client keeps asking them questions. Or a response to their empathic responses is if they feel like the therapist is doing something manipulative or has some other intention or something like that. I mean it depends on what the input is from the client and the situation. I mean it might be a management situation too. The person is struggling with whether to kill themselves or not and then the question is, is there something in addition to empathic understanding that seems like it would be appropriate in this situation. Sometimes it’s just something about the client or the way the client seems to be, or doesn’t seem to be making progress, something like that. One thing that comes up fairly often in the big scheme of things over the years is the therapist feeling that somehow they’re doing something wrong, insecurity in the therapist of some sort. Now, some consultation is identical to therapy and for me that’s fine. I mean if I don’t have some kind of institutional responsibility to fulfill, that I have to get in there somehow.

DM: In that case it can become much like therapy, is what you’re saying?

#1: No. I’m saying that if, -- If there’s some institutional requirement, that I’d sort of get that out of the way or I’d make sure I do that, whatever it is. The consultation might basically be the same as a therapy session with the consultee because the consultee is talking...
about maybe something that directly has to do with their response to the client or clients or it may have something to do with their life situation that is just so much on their mind that that’s all they can really, in an authentic way, give themselves over to, and generally those things bear on the quality of work. I mean if I can help a consultee in themselves separate from their work, it’s probably going to help their work too.

DM: So there’s a connection?

#1: Yeah, I feel that. And I feel it’s up to people, as much as possible, how they use the consultation.

DM: Okay. I’d be interested to hear about some of your “best” experiences of being a supervisor if you can think of them.

#1: Best. I don’t know how to answer that. Generally people are pretty satisfied and feel it’s helped them. I think that I’m very accepting. The set that I have with clients is generally pretty much the set I have with students, except that I have with students or trainees, a didactic part of myself in the relationship. I don’t have that with clients. I don’t know how to answer that. I mean I feel that the important thing is the acceptance of the student and giving the student a sense of being valued and appreciated, and supported. I feel I do that pretty well and that people respond and feel that. So I don’t know how to describe a particular one. Maybe I’ll think of something that stands out.

DM: I next want to ask the reverse, possibly some experience that’s been your worst or a sort of bad experience.

#1: Well, way back, probably 1961 or 1962, it was at the University of Chicago Counseling Center, there would be people going through the practicum in client-centered therapy, and those of us who were on the junior staff, as well as the faculty, would be the consultants to them for the therapy they were doing while in the practicum seminars. I did have a woman once who was kind of like a Lady Bountiful or something. In other words, her attitude toward clients was that she was somehow this great giver. (Laughter) She
gave all sorts of advice, all well intended, and even though she was a graduate student working on a doctorate, she seemed, -- To me she seemed dumb, except she wasn’t dumb. She just had a certain kind of intelligence that didn’t fit client-centered at all; she couldn’t get it, and of course, it was the counseling center. Although there was a general aim to help people to develop, just develop as therapists, it was a client-centered counseling center. I wanted to help them to become client-centered. I would explain things and she would agree and then she would just do what she wanted to do.

DM: So she would state her agreement as if she had gotten it and yet, the actions didn’t bear out.

#1: No, the actions and the actions she described herself. Not only listening to the tape. It was as if conceptually she had the words, but she didn’t have the attitudes at all, and it was very frustrating. I felt pissed at her. I don’t think I hurt her. I think she wasn’t a person who could be completely authentic. I don’t know. I didn’t criticize her, I just kept telling her that this is a different thing and providing her with what the assumptions were and she would nod.

DM: And go about her way doing her thing?

#1: Yeah. So that was very frustrating.

DM: So you said you became, -- you felt angry?

#1: I felt angry at her, yeah. I felt, “Why is she here, what is she doing here? Getting the benefit of this resource?” Of course, I didn’t like what she was doing with clients. People do things that I don’t like that they do. They report something and I can see how that could be hurtful to the client, and if I feel that, I feel kind of hurt for the client, I have a sensitivity about it, but then I feel my task is to help the person to respond differently, and I don’t usually get angry. This was a lot earlier in my career. Over the years I’ve become more accepting. I was very accepting already with clients, but with students, --

DM: So as a consultant or supervisor, you, --
#1: Yeah. I’ve evolved and become more what I want to be, which is really a supportive, understanding, acceptant person for the person working with me. That experience really stands out. Of course, there were other people who didn’t get it very well, but this particular person just seemed so self-satisfied in the way she was making pronouncements to her clients and then there was this weird agreement with the language of the theory and, complete contradiction -- very discrepant. I still should have been able to be more accepting in my feelings toward her. So it was hard working with her. I didn’t look forward to her coming in. But I haven’t had any problems in years with anybody. People made mistakes and they report it or reveal things that sort of upset me for the client, but I haven’t felt pissed at my students. Then people coming generally, they really want to learn and they’re open, and they try.

DM: So their intention when they come to you is to learn from you and learn the client-centered approach?

#1: Yeah, and if they make a mistake it can be hurtful, because sometimes the client can be somewhat hurt from their mistakes, but I don’t feel angry about it.

DM: My next question was going to be something about the nature and direction of your growth as a supervisor. You mentioned that you became more accepting over time. I wonder if there is anything else that comes to mind?

#1: I think that as I become more sophisticated in my theoretical understanding, that along with that, I’ve become freer to explain things to a student, to be directly didactic.

DM: Like you’ve become more confident in your, --

#1: Yeah, more confident, more competent, I think. Really more competent as well as confident. Definitely more confident, but more competent. I think that I have a capability to explain a problem so that it connects with the mind of the student pretty well. It’s from the years of teaching and articulating things in many different ways in many
situations that gives you sort of an adaptability in how you express theory.

DM: You find a way that fits for that person.

#1: Yeah, that fits for that person. I was more exclusively, empathically responsive in supervision situations on the whole much more early on and now it’s more of a mix.

DM: Of that plus the didactic, --

#1: Yeah. Because I feel that often I can impart some concepts in a way that give the person a better grasp of what they’re trying to do. That helps them to function better. That’s a way, I think, that I’ve developed and what I said before, I think that I’ve definitely become more accepting and more tolerant of mistakes, more easy in my own emotional reactions to mistakes. The subject matter is work with people, and so what this trainee is doing is affecting the people they work with and so there has to be, to help them, a generosity toward them and trust and good intentions. It’s the mix of attitudes that help you be accepting toward them and help them in a way that doesn’t set them back or make them scared or insecure.

DM: Or tentative or halting, --

#1: Yeah. It’s difficult. Let’s say the student is living with a kind of dislike of the client, some reservation toward the client, then I see my task as to help them find a way out of that so that they can relax with the client and be more accepting of the client, but until they do, I’m aware, --

DM: That they are where they are.

#1: Yeah, and the way that’s falling short for the client. It’s very important to develop a tolerance and generosity, acceptance, so that you really are supportive. People are going to do better if they feel supported, and yet I certainly don’t want to mislead people and give them the impression that when they’re doing X, Y and Z, they’re doing what I think is consistent with the approach. There’s an art there to
helping them. So I guess those are the ways. Of course, I just have much more experience as the years have gone on. I’ve dealt with more and more situations and give more examples of things that seem to relate or illustrate something.

DM: Okay. At this point what I’d like to do is take each one of the client-centered attitudes, some of them at least, and see if, in trying to maintain each of the attitudes, if and where that might have caused a problem or a dilemma. Let me start with non-directivity. My wheels are spinning a little bit with some of the things you just said. To the extent that you try to maintain that attitude with a trainee, --

#1: Okay.

DM: What I’m thinking about is the didactic piece might come into play sometimes.

#1: Yeah. As a supervisor, I have a directive intent that’s different than my intent in the therapy situation itself. I don’t know how to talk about kind of levels, -- I’m not invested in the way people work in the most general sense. It’s their business. People are doing all sorts of things. Most of the things they’re doing I don’t think are right to do and I think harm. But then most things also help while they’re harming, so I don’t know what it adds up to. I’m not a missionary, even though I’m committed to teaching this approach and I want to foster it, but it’s not a religious kind of feeling; or I don’t know what would that be. There’s a word.

DM: I was thinking dogmatic or, --

#1: It’s having the zeal, the righteousness, the conviction that makes one want everybody to be a certain way. I certainly wish that people who do therapy would do it from this framework, because I think it’s the most helpful, while being the least harmful. I don’t know how to express it. But there’s sort of structures here. In the most general sense, I would say I’m indifferent, but when it comes to my actual functioning as a teacher/consultant to somebody. As I said, I only want to do it with somebody who wants to learn from me, which means learning a version of client-centered.
DM: So within that context?

#1: So that’s a directive. I have a directive intention to help them become client-centered in the way they work. Then within that, I think that my more general therapeutic non-directive attitude tends to come and go in that situation. In general, I would prefer to conduct consultation along the lines that the student is inclined to receive it at the time and that’s what I generally do actually. But then I’m also motivated to teach and bring the person to a higher level of understanding. What I generally do is work out with somebody a kind of understanding. They will both ask me for ideas and I’ll say I can give you some theory on this or I can give you something on this. It’s like with our group. It’s getting permission to do it, even though it’s not an elaborate statement. I try to be sensitive. I don’t think I push that. That is, if the person’s just not open to it at the time or just can’t be open to it at the time, I don’t feel like I have to do that. In general, people are interested in hearing my ideas, because they find them useful, I think. They seem interested. So as a consultant, I would say that I have a propensity to be non-directive, but I also am interested in teaching, so sometimes I’m interested in explaining something or imparting something, which is a directive intention in the situation. So it’s a mixture.

DM: And it depends on whether the person is wanting something or open to it?

#1: Yes. One or the other, or it may be sourced in me, they might not even expect it.

DM: So in that case you might ask and then if they’re open, you’d go ahead?

#1: Right. Then with certain people who are ongoing, it just becomes a natural thing. They want to hear from me if I have something to say.

DM: So it’s sort of a natural agreement, to negotiate it as part of the process?
#1: Yeah, it’s implicit. They certainly could say, “I’d rather talk about something that’s going on with me,” or “I’d rather talk about this client, how I’m feeling about this client.” In teaching, you have to have a receptive person, so even for my didactic motivations, I have to be to some extent empathic and enter into the other person’s frame of reference enough to have cues that they’re with it.

DM: To know that that’s appropriate and that they’re waiting for that or wanting it.

#1: Yeah. Yeah.

DM: Let’s move on to the attitude of unconditional positive regard.

#1: I think that’s crucial.

DM: Have there been times when, for example, the Ms. Bountiful, --

#1: That’s the way I remember her.

DM: That might be an example.

#1: Yeah. It’s been a long time, that my acceptance is strong and my capacity to offer that in a consultative supervising role is strong.

DM: I wonder if you have an idea, -- I was just thinking of how it came about that you evolved in that direction where you were more acceptant over time.

#1: I think it comes from conviction about therapy or it’s sourced in the therapy work and the theory. I think unconditional positive regard, acceptance of a person, is just a big part of a good, favorable interpersonal environment. People are a lot more creative, constructive, more intelligent, more capable in a lot of ways if that’s their context of feeling accepted. So as a teacher and as a consultant, I want to achieve that in a consistent way, so it comes out of the theory and comes out of my experience. It comes out of my experience as a student. When I didn’t feel threatened, I feel I did better. I certainly felt better.
DM: So you, yourself experienced it and saw in yourself the benefit?

#1: Oh yeah, definitely. My first sense of it was through being sort of the client of my second husband who was a Rogerian psychologist and who offered that, along with teaching me the theory and teaching me about the therapy. -- He really was amazingly accepting and it felt right, it felt good. It was a very fostering relationship in that way. So it was a big part of my conviction when I started practicing, the acceptance, -- I felt it was clear; acceptance was basic to being a helper. The job was to find a way to be accepting and to change to become more accepting, have a wider range of situations and things that might otherwise bother you, become ones you could accept. Except for Ms. Bountiful.

DM: Okay.

#1: Yeah. I really had trouble with her. I regret that I couldn’t sincerely give her more. But I faked it, treated her respectfully, and didn’t feel good about it.

DM: We can move on to the attitude of empathic understanding. I don’t know if I understood, -- going down the list, some of these may not be things that are problematic, but, --

#1: You have to be careful if you’re teaching not to go too far in presenting your own frame of reference without touching in on the other person’s framework and so the way in which the empathic effort and process of interaction gets interworked with self-representing is in itself a kind of art. It is in therapy and it is in consulting. Of course, in explaining things, you get caught up. One does get caught up in explaining and loses touch.

DM: So you get so involved in explaining something that you kind of lose track of the other person?

#1: Yeah. I don’t touch in enough. I see that as sort of an ongoing thing. There isn’t some formula. It’s keeping in mind that you do want to maintain an empathic contact even though you’re doing an explanation of something. You do it better or worse, depending on all
the factors. I think it’s even more important with clients that your empathic orientation to the person remain very salient even if you’re answering a question or explaining something. There should be more restraint on one’s self in that mix than in the consulting situation. I think it depends on the trainee. I’m just using that word. Some of the people who come to me are very experienced therapists, they’re not trainees in any real sense, they’re very advanced. I’m using that term to refer to the role and the situation.

DM: What you are saying is that you try to keep in touch with the trainees in order to have a sense of what might be appropriate or acceptable or, --

#1: If you’re going on too long or whether you’re being followed. It may simply be, “Is this making sense?”

DM: It this useful?

#1: Yeah, right. “Is this enough?” There’s another example I’d like to give. Just being mindful that you’re not doing it just to enjoy your own capacity to theorize; you’re really trying to help the person get a better idea about something or get a different angle on it or whatever. Then of course, if it’s pretty much following the trainee because they’re talking about the client or they’re unfolding an experience or they’re talking about some personal matter, then it’s primarily empathic following. So it has a big role.

DM: Is there ever a time where it can become problematic that you can think of?

#1: Well, no. Just that wanting to maintain the empathic connection in a didactic piece isn’t as easy as simply following.

DM: Yes, as you were describing, it’s almost like an art form.

#1: Yeah. I think it is kind of an art form. With a client there might be a kind of conflict. Not in the sense that I believe one should not respond to the question, as a question. It might be I don’t have an opinion. But with a client, I think there should be more of a struggle,
because you want to maintain the empathic relation and yet you want to respect the person by honoring their question or their request. The art is not as easy. It’s easier with a consultee, “What do you think about what I did?” she asks. I just shift over. Not that there isn’t still a concern, because if I think they made a mistake, then I have to be mindful of how I would, --

DM: The impact of what you might say.

#1: Yeah, because I don’t want to hurt them and I don’t want to punish them by a criticism. So then it becomes sort of the art of giving a criticism in a way that’s least likely to be felt as punishing. With a client, I think it’s sort of a higher art and more of a struggle, and there should be. There is a kind of conflict of purposes. You want to meet the situation. It’s the different manifestations of the non-directive attitude. One manifestation is to honor the person’s want, what they want in a situation. The other is to not direct them or influence them any more than possible.

DM: Right.

#1: But it’s the non-directive attitude being manifested different ways, contradictory ways in the same situation and so it’s more difficult.

DM: It seems very subtle.

#1: It’s an art.

DM: Okay.

#1: Next is congruence?

DM: How did you know?

#1: It’s essential. I view congruence as basically the integrated state of the therapist and I don’t view communications as congruence. Statements can be congruent communications, but they’re not the congruence. Congruence is the integration or in more strict theoretical
terms, the isomorphism of the experience to the symbols or the isomorphism of the symbols and the language, which is a very complicated thing, I think. Basically, its genuineness, authenticity, transparence in the sense that you are what you seem to be, which I wasn’t with the Lady.

DM: You were one thing and, you -- felt something different.

#1: Yeah. I didn’t know how to meet the situation with all the attitudes at that time with that person. I think that being in an integrated state and to have the techniques. First of all, self instruction and then you go into consultation and you aim to be integrated. I think that’s a pretty relaxed state, a responsive state; not a tense responsive state, a more relaxed responsive. Hopefully you won’t have anything else on your mind, so you can be genuinely empathic.

DM: And have a presence and can be with the person.

#1: With your whole presence, giving attention to the person, undivided attention and extending your interest. There is part of the self instruction which is to be present. Because if you just give yourself the instruction to be empathic, acceptant, congruent, non-directive, and this whole meld of things, then you’re going to have a presence. But, if you’re coming out of distractions of various sorts, it doesn’t hurt to say, “And be present.” It’s sort of like an extra push to be there, which is basically to give your attention fully there. Being present is just bringing into the forefront of one’s self these attitudes, that is therapeutic presence, that’s the way I think of it -- I think one wants to have basically a therapeutic presence with a consultant even if one has some didactic purposes.

DM: Okay. I want to check in with you and see how we’re doing on time. Are you okay?

#1: Yeah.

DM: As we’re going along on the questions, I feel like some of these following questions may have been touched, but I’d like to just ask them anyway to see if there’s anything else that comes to mind. Next,
I’m wondering how you have addressed situations where you felt like the trainee or the supervisee isn’t, -- You felt they weren’t doing very well in their work with the client.

#1: What about that?

DM: How you might address or how you have addressed that situation. A situation where you’re let’s say listening to a tape or you’re listening to the person’s dialogue about the client and they’re not doing very well. How might you approach that?

#1: The people I have been working with in recent years generally, -- they bring it up, usually, that there’s something wrong.

DM: So they realize it.

#1: They realize they’re something wrong and they want my help in teasing out what it is and help them to change that. Usually, I just observe. I might say, listening to a tape, “Your tone doesn’t have as much warmth as I think would be best, that I think you have with other clients. Is there something about this?” Or if I’m listening and I hear a person’s empathic responses seem to be off, they don’t seem to be as accurate, I just would directly say my observations. If it’s what they’re describing and they’re describing something that to me sounds problematic but they’re not acknowledging that they perceive it that way, then I’d probably do the same thing.

DM: So you notice something and then you, --

#1: I ask, and bring it up. The first step is, “Do you see it? Do you see what I’m referring to?” “Do we have consensual observations here?” If there’s that, then the next thing I would ask them, “Do you have any idea what’s affecting you? Is it something about the client or yourself?”

DM: I’m just wondering about the case where you notice something and you bring it up by asking if they recognize it as well and they say no, I don’t.
#1: I can’t remember any examples of that, but it probably has happened.

DM: If there’s not agreement?

#1: If there’s not agreement, I probably would say let’s just keep an eye on that, because it seems that way to me.

DM: And kind of let it go at that point?

#1: Yeah. If the person didn’t see it or for some reason is unable to at that time. I might be able to drop it, but then ask them a question about how they’re feeling, something kind of specific to check out and it turns out that they are aware of that, and it’s something that could be affecting behavior. That came up not too long ago. The consultee was suffering from some physical pain and I knew about that, and then there was something that I thought was kind of overly intense in the way they were relating to the client and they didn’t think so and then I asked about how much they were having pain at the time and then they remembered that they were. So then they thought maybe there was some tension that they couldn’t hear, but they were thinking of that and had forgotten about the pain but then remembered. That sort of thing, knowing something about what’s going on in the person’s situation.

DM: Might lead you to some, --

#1: Might lead to some connection, yeah. Mostly people see what I see and they’re more likely to mention it first. If a student feels safe with you, then they don’t hide things. They’re in a more open frame of mind. They noticed something they hadn’t even thought about in the context, with you, because they’re comfortable. I think some of these problems have been more with someone who was really aiming to be a different kind of therapist.

DM: My next question was going to be on that very topic, although we touched on that very early on, so I’m not sure if it’s even worth asking the question, but it would have been, having interest in your experience of supervising people who are even not committed to
client-centered therapy or felt that they were, but you had a sense that they weren’t.

#1: You know, I’ve taken that on in private consultations.

DM: You’ve taken on people that, --

#1: The funny thing is that people will, -- Susan and Marge and others will tell you this too, that people who are functioning a very different way will come to a client-centered therapist or sometimes come for a client-centered consultation because they really want the acceptance. (Laughter) It’s kind of weird because why is this person coming to a client-centered therapist, and they’ve been coming for three years, you know. (Laughter)

DM: And they’re not making the crucial connection. (Laughter)

#1: Somehow what’s good for them isn’t what they think is good for their clients. (Laughter) It’s very strange.

DM: Or what’s good for them as a client isn’t good for them as a therapist.

#1: I don’t know. It’s very puzzling. In the last few years, a couple have come in. It hasn’t been a problem, but I think if I were to work with them on a regular basis for consultation it could be. They might be using it differently in thinking the use is really kind of working through a problem, an upset with a client or some difficult situation with a client and basically almost all that’s required is to be with them in the same way as with a client, -- just accept what they’re presenting, and they explore a problem. Clients explore problems from perspectives that I don’t agree with, and it’s irrelevant that I don’t agree with them, because that’s not my set whether I agree or disagree. I’m just there to understand.

DM: Like someone exploring something from a religious point of reference or, --

#1: Right. Do it all the time.
DM: And here, their “religion” is some other orientation.

#1: Yeah. The belief system is different from my own, but it’s irrelevant that it is not from my point of view. Of course, if they were going into some of their thoughts about what they ought to be doing with clients and wanting, -- we might have problems.

DM: Wanting validation or, wanting advice in that regard?

#1: If people are just assuming that getting the client to address such and such a problem, -- For example, I wasn’t the consultant, but Myra Leifer used to work at the University of Chicago and I had dropped in to see her. She was supervisor of the department, and one of her staff came in. The woman was all up in arms because she was working with a Latino family where the toddler-age child was in the family bed, which I consider perfectly normal in any culture, but certain in the Latino culture. This woman was acting as if somehow she had to get this family to stop doing that, and I was just there. I had nothing to say. If she had been coming to me about this situation, we would be in direct opposition. She felt this had to be changed and her task was to get these people not to do this, and so that would be an example.

DM: I wonder if you have an idea what you might have done in that situation if you were the consultant.

#1: Well, it would be difficult. I don’t know. It’s hard. I would have to challenge her assumption somewhere in there. I probably would ask her if she’d be willing to explore her feelings about this and the concerns that she has about it and so on, because probably there’s a morass of theoretical and personal stuff that’s mixed up in her reaction to that, fears of abuse, a mixture of concerns and assumptions and ignorance, and as far as I can tell, she didn’t have any grounds to think that there was anything wrong going on. They were not people fucking their kid. They were just doing what they do to sleep. Kids sleep in the same bed as the adults, so probably if I did it right, I would start with asking if she would go into what her whole context is and that might be resistant, so I’d probably start by saying that whatever you need to do in this situation you’d be able to do it best if you’re not as
distressed as you are about it, so let’s see what your feelings are, which might work. I mean it’s true.

DM: When you say which might work, work to?

#1: Which might work in the sense that she would be willing to do it, to explore her feelings.

DM: To not resist that.

#1: Yeah. To ask someone to do that when they’re saying this is just an awful situation and they’re all upset about it, to intervene in effect by saying I think that one thing that might be helpful here is for you to review what the factors are in your reaction to this to see what’s at work. “Why should I do that, this is a bad situation.” I think whatever is best to do in the situation you’ll be able to do better if you’re not so worked up about it and it’s obviously upsetting you. I don’t know if that would work or not in the sense that the person could say “you’re right” and go into it or they could be, -- That’s an example.

DM: I just wish you’d tell me how to do this thing I need to do.

#1: Yeah. She needed to have a little perspective for one thing, a cross cultural one. She was really panicked about it.

DM: I wonder, do you think you would try something didactic from the cross-cultural standpoint in that case?

#1: Yeah. It depends where. Another way to go about it is say, “Can I give you some perspective on this kind of situation?” Again, I don’t know whether the mind would be open.

DM: That’s where you need to touch on the person’s frame of reference to see what might be appropriate or workable.

#1: Yeah. There are different strategies, I think, in that situation. That’s a situation where the person is coming from really a different view of therapy in the first place. Because a client-centered therapist
could be ignorant about those matters too and be upset about it, but they would already be looking at it as a problem in acceptance and what to do in the situation where they think there might be some kind of abuse to the child going on and how to work with that. So you’d already be a step closer and it would be easier to give perspective.

DM: Okay. I’m getting towards the end here.

#1: Yeah. I should stop soon.

DM: Okay. Let me ask just one last question. The topic I have is dealing with so-called ethical issues or issues relating to following a code of ethics for our profession. My understanding of what I call a more mainstream or traditional role of a supervisor is to insure that ethical standards are met, etc., and I’m wondering if that plays any kind of role in what you do?

#1: Depending on the student’s background, I may suggest they read the APA ethical standards and discuss their reactions with me. If the student is getting close to overstepping any ethical standards, I discuss it with them and inform them of the problems that may come up for the client, for themselves, for their employment setting. We spend time focusing on their feelings, views, or limitations that are bringing them into this realm. I am not moralistic about the ethical standards and tend to emphasize that the standards are there, whether one agrees with all of them or not; breaking them puts the therapist at risk, even if there is no harm to the client. In regard to romantic or sexual attractions to client, I try to help students explore their feeling and avoid physical expressions of those feelings. I recommend transferring the client if the therapist’s emotional responses, positive or negative, are strong enough to color their therapeutic behavior or lead them out of the therapeutic range. There are more situations where therapists have trouble accepting client than situations where they are in love with or sexually enthralled by clients. Either way, therapists need help in transcending those feelings to be effective with specific clients and I tend to be very accepting towards them as part of how I help them.
DM: Okay. I’m going to stop here with the questions. I wonder if you have any questions of me at this point regarding the interview or the study or if you have any reaction?

#1: No. I think the interview is good. I think you’ll get some interesting variations in people.

DM: One thing I’m thinking about now and I don’t want to take any more time. There’s one question I should ask and that is, is there anything we haven’t talked about that you feel is important regarding this topic? Either client-centered supervision or issues that might come up?

#1: I can’t think of anything, no. I think it was a good interview and well connected.

DM: Thank you.
The Person-Centered Journal

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