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# THE NONDIRECTIVE ATTITUDE IN CLIENT-CENTERED THERAPY [1]

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Client-centered[2] therapists are unique in the extent of their commitment to be of help without disempowering their clients. The theory of the person-centered approach (Rogers, 1980) is based on the hypotheses that all humans have innate power and capabilities for personal growth and have pro-social tendencies. Further, that these capabilities can be realized more fully under the facilitative interpersonal conditions of congruence, unconditional positive regard and empathic understanding. In the theory of therapy, clients' potentialities for healing and further growth are freed and accelerated when they perceive the congruent therapist's acceptant empathy and when the therapist at the same time avoids disempowering attitudes and behaviors in the relationship.

Client-centered therapists' commitment to avoid client disempowerment during the processes of helping is realized and is expressed through their adherence to the nondirective attitude. The nondirective attitude, in client-centered theory, adheres within the meld of the basic therapeutic attitudes. It is a quality intrinsic to the therapeutic attitudes, It influences the therapist to protect the client's self-determined processes that promote the client's selfempowerment. And it fosters the avoidance of therapist intentions and behaviors which might disempower the client. This paper is intended to clarify the meanings and some of the implications of the concept of the nondirective attitude in client-centered therapy as they apply to the therapist. Implications for the client will be discussed in another presentation.

## DEFINITIONS

Webster (1979) defines the verb "to direct" as "to manage the affairs of; guide, conduct, regulate; control; give authoritarian instructions and ordain (that a thing be done); order, command" (p 516). In the adjectival form, "directive" is defined as "tending to or intending to direct" (p 516). Obviously, "nondirective" means something opposite to the meanings of "to direct" and "directive." Thus, the "nondirective attitude" literally refers to an attitude in which one is not intending to manage the affairs of others, not intending to give guidance, not intending to conduct, regulate, command or control others. Clearly, the client-centered nondirective attitude is not a paternalistic attitude; and it is an anti-authoritarian attitude.

The nondirective attitude can be defined, also, in positive terms. The positive meanings of the concept require reference to the values that inform the attitude. The philosophical orientation of client-centeredness (Rogers, 1951, Chapter 2), primarily asserts the idea of the inherent and precious value of human persons. It asserts the values of respect towards and trust in persons, egalitarian and democratic values and the value of freedom understood partly in terms of John Stuart Mill (1859) ". . . that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it..." (Lerner, 1961, p 266). The nondirective attitude in client-centered work exists in the therapist's intentions to experience the values of respect and trust as consistently and deeply as possible and to act in relation to clients only in ways that express these values.

The nondirective attitude is intrinsic to and necessary for true client-centered work. Without proper cognizance and inner experiencing of the nondirective attitude, the therapist is inadequately prepared to function in a client-centered way with a wide range of clients with their suprising and varied characteristics and expectations. Without it the therapist has insufficient inner guidance as well as inadequate criteria for response limitations in interaction with clients. Without the guiding and the limiting role of the nondirective attitude, for example, congruence can be construed as self-disclosure, unconditional positive regard can be construed as praise of the client and empathic understanding can be construed as the therapist's imaginings about the client.

Some therapists who work from Rogers' basic philosophical orientation and the theory of the therapeutic attitudes, but without cognizance of the nondirective attitude, evolve somewhat different forms of therapy in which particular directive principles are brought into the therapeutic process[3]. The popularity of these deviations and the related loss of focus on the value of client-centered work is one reason for my attempt to bring attention to the nondirective attitude. The non-directive attitude needs to be explicitly incorporated into client-centered theory and practice. It is necessary in order to preserve and further develop a relatively pure and highly effective form of client-centered therapy so it can continue to be available as a choice for therapists and clients.

## SOME HISTORY

Many therapists have been influenced by Rogers's philosophical orientation (Rogers, 1951, Chapter 2) and generic theory of therapy (Rogers, 1957). Some mistakenly have identified pure client-centered work with a rigid and limited responsiveness they associate with nondirectivity. (See Lietaer, 1997). Rogers recognized this misunderstanding, it disturbed him, and it was one of his reasons for abandoning the term "nondirective." After the early 1950s Rogers's only use of the term is in his references to the history of client-centered therapy.

Nondirective, understood as an **attitude** rather than as the name of his early conceptualization of client-centered therapy or as the name of a technique in that early therapy was never explicit in Rogers's writings. In *Client-Centered Psychotherapy* (Rogers, 1951), the nondirective attitude comes across implicitly in the therapist's intentions to give all of his or her attention to the client in order to acceptantly and empathically understand. It is also implicit in the client-centered operational philosophy placing high value upon respect for and trust in the client. The term is explicit in the title of Raskin's 1947 paper, "The Non-Directive Attitude." Raskin, in this paper, coined the concept. Rogers (1951) commented that Raskin's paper gives "a vivid description .. . of the counselor's function"(p.29). Raskin wrote:

> There is another level of nondirective counselor response which to the writer represents *the* non-directive attitude. At this level, counselor participation becomes an active experiencing with the client of the feelings to which he gives expression . . . he tries to get under the skin of the person . . . And in struggling to do this, there is simply no room for any other kind of counselor attitude . . ." (p. 29).

But this citation from Raskin's paper is the sole reference that I have found where Rogers explicitly acknowledges the concept of a "nondirective attitude." Nevertheless, it remains implicit in Rogers's theory of therapy and writings about therapy until his death. Also, it is ubiquitous in his own therapy.

Examination of Rogers's own therapy behavior shows that he is systematically and very consistently nondirective in his relations with his clients and in the manner of his empathic responding to clients (Brodley & Brody, 1990; Brody, 1991; Nelson, 1993; Brodley, 1994; Merry, 1994). For example, in a sample of thirty-one of Rogers's interviews, 90% of his responses are nondirective, empathic following responses (Brodley, 1994). Most of the other 10% of responses – those made from his own frame of reference – are also nondirective and have empathic qualities.

Indeed, there are some exceptions to nondirectivity in available examples of Rogers's therapy (Bowen, 1996; Brodley, in 1996a). But directive responses are rare exceptions and constitute only a very small portion of Rogers's behavior in the few sessions where they can be found[4]. Whatever Rogers's reasons for the exceptions, they are exceptions. Rogers's own therapy behavior, from the 1940s until his last demonstrations in 1986, almost entirely manifests the nondirective attitude.

## IMPLICATIONS

Implications, for the therapist, of the nondirective attitude in client-centered therapy occur in two different arenas. One arena is the personality and subjective life of the therapist. The other is the arena of behavioral expression of the attitude. In regard to the arena of therapist personality and subjective life, the social, cultural and professional contexts of the therapist are additional determinants, and often are obstacles.

## THE THERAPIST IN CONTEXT

The therapist who adopts client-centered values must be – by nature or nurture – a nonpaternalistic, an antiauthoritarian, a democratically oriented personality and be able to resist the prevailing cultural climate of authoritarian values. Client-centered values are in conflict with the systemic paternalistic and authoritarian values of the institutions and practices that permeate all cultures which have formal psychotherapeutic practices (as well as most cultures that do not).

The therapist who is inclined to adopt the philosophical orientation and practice of client-centeredness is pushing his or her non-paternalistic and non-authoritarian tendencies further away from societal norms. The therapist, as well, is almost inevitably functioning in the context of the prevailing authoritarian and paternalistic clinical culture. Consequently he or she must often tolerate relative isolation from like-minded colleagues and persist in a life of considerable incongruence with the social context of work. Tolerance for criticism, tolerance for conflict, capability for independent thinking and propensities for maintaining integrity, maintaining valued principles and self-direction while in a marginal position are necessary characteristics of, or ones that need to be developed by, client-centered workers.

## A PHENOMENOLOGY OF THE NONDIRECTIVE ATTITUDE

The phenomenology of nondirectivity as it is lived in the therapist's subjective experience involves the development of specific kinds of sensibility and sensitivity. This sensibility is difficult to describe and undoubtedly varies with the individualities of therapists. The following description is based on my own phenomenology as well as upon impressions I have gleaned from other client-centered therapists. It is not meant as a model, but is intended to illustrate how a nondirective phenomenology can have both a guiding and inhibiting character.

The guiding character of the client-centered therapist's nondirective sensibility seems to exist as a **drive to understand** – empathically and accurately – without interfering in, or contributing additional meanings to, the client's flow of thoughts and feelings. It is a drive to understand what it is the client is intending to express or communicate on a moment to moment basis. The drive feels like a vivid interest to take in what it is the client is pursuing in his or her narrative. The therapist feels this drive-like interest even before experiencing concrete understandings. It also involves a motivation to differentiate the therapist's own input or own shades of meaning (subjectively and prior to communication) from those the client appears to be transmitting. It is an interest in knowing the other as the other perceives and knows him or herself.

The nondirective sensibility also feels like a **drive to respond with attunement.** It is a desire to be close to, to feel and to respond with acknowledgment of the client's intonations and other expressive behaviors that convey specific meaning and feeling. It also involves awareness of, and concern for, the client's autonomy and right to self direction. These attunements shape the therapist's expression. The attunement element seems inextricably bound to **responding and being responsive** to the client while respecting the client's autonomy and self direction.

The nondirective guiding sensibility also involves a feeling of humility. In the process of empathic understanding the therapist feels tentativeness, and some degree of uncertainty, in respect to the understandings achieved. Empathic understanding responses are always imbued with the question to the client: "Is this (meaning or feeling) accurate according to your sense of what you were intending to express to me?" The humility in the client-centered sensibility is based on respect for the client and on the belief that the client is the expert and authority about his or her own experiences and truths.

There is also an inhibiting sensibility that is an aspect of the phenomenology of the nondirective attitude. It shows up in the absence of paternalistic or authoritarian kinds of reactions to clients. This inhibiting sensibility is not a form of incongruence.[5] Congruent inhibition most likely involves a preconscious sorting out of paternalistic or authoritarian responses in the therapy situation. I suspect this to be the case because many client-centered therapists, including myself, have paternalistic and directive reactions in other situations. If such reactions begin to occur, of course, inhibition is a conscious and careful process. It involves their full identification and consideration, not a knee jerk type of reaction.

In addition to the guiding and inhibitory processes that seem to be involved in the nondirective attitude with one's own clients, there are subjective responses to the therapy work of other therapists that seem to arise from having a nondirective phenomenology. These responses are feelings of pleasure and well being when witnessing nondirective empathic processes between another therapist and client. Respect for the client, protection of the client's autonomy and consequent empowerment of the client are apparent in nondirective processes, making them enjoyable to behold. Disturbed reactions occur as well, when witnessing directive processes in the work of other therapists. These responses, both positive and negative, are an immediate kind of experience and, depending upon the nature of the perceived directive behaviors, variably intense.

## BEHAVIORAL IMPLICATIONS OF THE NONDIRECTIVE ATTITUDE

The most frequent and most natural behavioral implication of the nondirective attitude occurs in the therapist's **empathic following** of a client who is talking voluntarily to the therapist and expressing his or her thoughts, feelings and concerns about his or her self and life. These responses are expressions of the therapist's acceptant, non-judgmental, empathic following and understanding of the client's self-directed communication and its experiential meanings. I have termed the whole interactive pattern "the empathic understanding response process" (Temaner, 1977). It is also referred to by Barrett-Lennard (1981) as "the empathy cycle."

The therapist's empathic, following, verbal responses along with his or her expressive behavior of face, gestures by hands and arms, body language, posture and movements, the therapist's tone of voice and phrasing of sentences – all together express the therapist's nondirective attitude in response to the self-representing client. These empathic responses and concomitant behaviors together express all of the therapeutic attitudes [6]. Rogers (1951) described this basic expression of the therapeutic attitudes:

> . . . it is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client (p 29).

Empathic responding is an optimal form of client-centered implementation because it can nondirectively express all of the therapeutic attitudes[7]. It is a straightforward and respectful response to the client's hope and intention, when talking about him or herself, to be understood. People usually want and expect to be understood when they talk to another person. This is more so in the context of therapy. Thus, in following the client – through acceptant, empathic understanding of the client in the moment – the client-centered therapist is being responsive to the client's wishes and expectations, not imposing a form of response on the client.

The behavior expressing empathic understanding in client-centered therapy is basically an interactive, relational activity. It is not a series of unrelated discrete responses to client's utterances. Instead, it is a process in which the therapist tries to accurately represent his or her experiences of the client's intended communications, followed up by the client validating, correcting, modifying, elaborating on his experiences, and the therapist's further empathic understanding.

In empathic interaction processes, the therapist's verbal statements of empathic understanding are always tentative. They imply the sincere question "Is my understanding accurate?" The therapist intends his or her specific empathic responses to check with, or find out from the client, whether or not the therapist's communicated understanding is accurate according to the client (Brodley, 1984; Rogers, 1986).

The client's responses that verify, deny or qualify the therapist's accuracy of understanding are essential to empathic understanding. The therapist's verbal empathic responses, along with qualities of his or her voice and gestures, contribute to the client's perception of the therapist's authenticity and acceptance and communicate the therapist's intentions to be respectful and to not be controlling or directive. The client's responses of validation, correction and further development of thoughts and experiences tend to confirm the therapist's sense that his or her authentic inner attitudes of acceptance, understanding and nondirectivity are being communicated as intended. The interaction is mutually supportive towards more of the same kind of interaction – the client continuing to narrate and communicate with the therapist and the therapist trying to accurately, acceptantly, empathically understand. Therapeutic change, according to Rogers (1957; 1959), occurs when the client perceives the therapist's therapeutic attitudes. Perception of the therapeutic attitudes by the client usually appears to involve the client's consciousness of the therapist's intent to understand and the client's consciousness of the therapist's accuracy of empathic understanding. Clients' responses, such as "exactly," "yes," "well, not quite as . . .," "no, I meant . . .," etc. seem to demonstrate their consciousness of the therapist's intention to empathically understand.

Spontaneous client statements usually do not reveal whether or not clients are equally conscious of the therapist's attitudes of acceptance, genuineness and nondirectiveness. In many client/therapist interactions the attitudes may be subceived (see Rogers, 1959, pp 199-200) and in this way contribute to the therapeutic climate. Whether or not the client consciously appreciates them, their impact on the client is one of a mixture of qualities that are important in having therapeutic effect. An aspect of the therapeutic impact of the behaviors that are shaped by the nondirective attitude is client's perception of the therapist's respect for and trust in the client. This respect and trust is implied in the empathic interaction with its inherent protectiveness of the client's autonomy and self-direction.

Empathic responding is both rightly and wrongly identified with client-centered therapy. It is rightly so identified because it can be an authentic, appropriate, optimal realization of the therapeutic attitudes and responsive to the client's hope of being understood. It is sometimes wrongly identified with client-centered therapy when it is thought to be the only form of response consistent with the nondirective attitude.[8]

## RESPONSIVENESS TO QUESTIONS AND REQUESTS

Responsiveness to clients' questions and requests is the second major behavioral implication of the nondirective attitude.[9] Students sometimes assume that it is outside the scope of client-centered work to answer clients' questions or to honor clients' requests. Although incorrect, this conclusion is understandable because such behavior does risk influencing clients' choices, risks deflecting clients from their own exploratory process and risks undermining their self-direction. To avoid these risks of directive effects when their clients ask questions or make requests, some students of the approach tend to limit themselves to responding empathically to clients' feelings or motivations.

Empathic responses, sometimes, may be an adequate response to a client's questions or requests. When a client asks question or makes a request the therapist may feel the need to be sure he or she understands the client's subjective experience that has stimulated the question or request. Or, the therapist may want to be sure the client meant the question as a question. In either case, an empathic response may be an adequate response from the client's point of view.

From the context of a question, the therapist often has enough information about the client's immediate frame of reference to have a basis for an accurate empathic understanding response, or at least for an empathic guess. Indeed, a client may feel a therapist's empathic response is more helpful than whatever answer the therapist might provide. If, however, the therapist's response to a client's intended question or request is limited to an empathic response, the client's intention – to be answered – has been ignored. The experience of being ignored, particularly if it occurs frequently, tends to diminish any person's sense of self and their sense of personal power in the situation.

There is a therapeutic problem even when clients do not object to their questions being left unanswered. Clients may interpret an empathic response as an avoidance of the question and further, as indication that the therapist should not be asked questions. When this is the client's interpretation, the client's freedom of expression in the relationship has been diminished. An instance of avoidance of a client's question or request may not inhibit or disturb the client. If questions and requests are deflected by empathic responses frequently or systematically, however, the effect is likely to be one of disempowering the client to some extent. Any disempowerment of the client in client-centered therapy is viewed as countertherapeutic.

Systematic avoidance of clients' questions and their requests is, effectively, a form of control over the therapeutic process and over the client. It diminishes the client's freedom to bring out his or her felt needs in the relationship. Diminished freedom may be the consequence of not responding directly to questions or requests even if the therapist is highly empathic to the client's motives and feelings and feels committed to empowerment.

The nondirective attitude in client-centered work implies that questions and requests should be respected as part of the client's rights in the relationship. These rights are the client's right to self-determination of his or her therapeutic content and process, and the client's right to direct the manner of the therapist's participation within the limits of the therapist's philosophy, ethics and capabilities. The result of the therapist's respect towards these client rights is a collaborative therapeutic relationship (see Natiello, 1994).

This conception of the client's rights in the relationship is radically different from that of other clinical approaches. In other approaches, to a greater or lesser extent depending upon the theory, the therapist paternalistically decides whether or not it will be good for the client to have his or her questions answered or requests honored (Glickhof-Hughes & Chance, 1995). The client-centered approach eschews decision making for the client. Decisions are collaborative, with the client almost always leading the process.

While being responsive to questions and requests the therapist also continues to maintain congruence and continues to experience and implement the therapeutic attitudes of unconditional positive regard and empathic understanding. The therapist continues, as in empathic understanding response process, to respond to the client in the question or request situation from the client's internal frame of reference. But responsiveness to questions and requests also involves the therapist in responding to the client from the therapist's own internal frame of reference. Addressing questions and honoring clients' requests is, consequently, a more complex implementation of the therapeutic attitudes than the empathic understanding implementation.

The client-centered therapist aims to maintain the attitudes of congruence, unconditional positive regard and empathic understanding even in situations of bringing his or her frame of reference, own self and/or specific capabilities or expertise into the foreground of interaction with the client. The situation of answering questions or accommodating to requests makes the therapist's moment to moment attention to and attunement to the client more difficult to maintain. This is because it is being interrupted by a focus on the therapist's own internal frame of reference.

While the therapist is responding authentically and deeply to the client's question or request throughout the interaction that deals with these, the therapist must focus into him or herself and attune to his or her own experiencing processes and cognitive processes. Attunement to the client and the client's frame of reference is to some extent interrupted when the therapist is accommodating and trying to make his or her responses coherent, empathically relevant to the client, and at the same time self-integrated responses – not off the top of the head responses. Difficult as it may be, responding directly to questions and requests can be and should be from the therapist's empathic and personal depths as much as pure empathic following.

## THE THIRD MAJOR BEHAVIORAL IMPLICATION

The third major behavior implication of the nondirective attitude has to do with ways the therapist does **not** behave in client-centered therapy specifically in order to avoid disempowering the client in the relationship. In effective client-centered therapy the therapist experiences acceptant empathic understanding and maintains an integrated, congruent state as consistently as possible. Maintaining this combination of attitudes and behaving consistently with and expressively of them constitutes the therapist's active role in the relationship. Not less important, however, is the task of avoiding directive intentions and avoiding behaviors that the client is likely to interpret as implying the therapist has goals for the client.

The basic definition of the nondirective attitude states that the therapist does not intend to manage, give guidance to, conduct, regulate, or control the client. In more specific terms the client-centered therapist does not intend to diagnose, create treatment plans, strategize, employ treatment techniques, or take responsibility for the client in any way. These authoritative intentions are the usual ones that are based on the standard psychotherapy paradigm in which the client is viewed as sick and the therapist is viewed as responsible for the client's diagnosis, treatment plan and cure. There is a profound difference in a therapeutic relationship between the situation of the therapist having the standard paradigm goals for clients and the client-centered relationship in which the therapist has no such goals.

In client-centered work there is only the very general therapy goal of effectively helping the client by providing the therapeutic attitudes in the relationship, and doing so without hurting or disempowering the client. In the collaborative therapeutic relationship of client-centered work the therapist keeps him or herself free of all other goals and intentions for clients and only rarely engages in behaviors that typically express these goals and intentions.

The client-centered therapist does not usually [10] take a history, does not question the client for the purpose of establishing a diagnosis, does not ask leading or probing questions, does not volunteer interpretations or explanations about the client to the client, does not advise, does not volunteer reassurance, does not evaluate the client's ideas or plans, does not try to control the manner or style of expression in which the client presents him or herself, does not decide for the client about the frequency of sessions, the length of the therapy nor guide the process of stopping therapy[11].

The client, however, may make requests or initiate experiments during which the therapist engages in some of these behaviors. Or the therapist may on rare occasions, unsystematically [8, 12], volunteer some of these behaviors. Without abandoning the philosophical orientation of client-centeredness and while still committed to the therapeutic attitudes and the nondirective attitude, the client-centered therapist remains free to behave in whatever way his or her best judgment or therapeutic instincts leads or demands of him or her. The client-centered therapeutic relationship with each client is viewed as unique, complex and unpredictable. The client's manner and processes of change are unique to the individual, so there can be no formulas or rules to follow.

The client-centered values and attitudes, however, result in the therapist tending to have certain subjective experiences, tending to engage in certain behaviors, and tending to avoid certain other behaviors. The therapist's experiences and behaviors are determined by values and his or her perceptions of the moment, not by rules. Consequently it cannot be being true to the practice to assert that behaviors associated with directivity are impossible in the context of client-centered work. The client-centered therapist's freedom, however, is embedded in value determined disciplines. It is both a creative and a disciplined freedom.

## SUMMARY

The implications of the nondirective attitude for the therapist in client-centered therapy are in the arenas of the therapist's subjective life and in his or her communicative behavior during therapy. In the subjective arena, the nondirective attitude and therapeutic congruence together require a long process of self-scrutiny and self-definition in order to be able to counter early learnings, as well as to counter social/contextual pressures towards paternalism and authoritarianism. In the arena of therapeutic behavior, the nondirective attitude contributes to the form of response made to self-exploring, self-expressing clients – the empathic understanding response process (Temaner, 1977). It contributes to accommodative responsiveness to client's questions

and requests. And it contributes to avoidance of behaviors that might undermine the client's autonomy and self-determination.

Client-centered theory and its practice are clarified by understanding the important role of the nondirective attitude in the therapist's intentions and by maintaining that attitude in the context of providing the therapeutic attitudes of congruence, unconditional positive regard and empathic understanding. Rogers theory of therapy is a theory for client empowerment and the nondirective attitude is primarily the therapist's inner guide for protecting that empowerment.

## NOTES

1. Revision of a paper presented at the Ninth Annual Meeting of the association for the Development of the Person-Centered Approach (ADPCA), Kendall College, Evanston, Illinois, May, 1994.
2. Client-centered therapy and person-centered therapy refer to the same therapy. The term "client-centered" will be used in this paper.
3. Examples of therapies based on Rogers's theory which also utilize directive principles are E. Gendlin's experiential therapy (Gendlin, 1973; Brodley, 1990), Friedman's experiential therapy (Friedman, 1982) and F. Gerbode's traumatic reduction therapy (Gerbode, 1992; 1994). In Gendlin's and Friedman's approaches, experientially focused process of client self-explication and self-expression is considered the essence of, and necessary for, therapeutic change. Consequently the therapist has a responsibility to intervene and to promote that specific client process if it is not occurring spontaneously. In Gerbode's approach, the therapist gives instructions and guides the client through specific procedures in order to dispel the emotional charge and other symptoms of post-traumatic conditions.
4. In the instances where directivity appears in Rogers's own therapy behavior, it may be that Rogers was experimenting with some directive intentions or, alternatively, Rogers may have allowed himself to drift from his otherwise very pure nondirectivity – a loss of discipline – perhaps following some idea or impulse in those moments, or they are instances of idiosyncratic therapist freedom and not meant to be explained beyond invoking that principle.
5. This is a complicated issue. Inhibiting contradictory attitudes, in this context means one is not experiencing them at the time with the particular client. Thus they cannot be affecting the interaction. The therapist is not incongruent, however, even if experiencing attitudes that are inconsistent with empathy and unconditional positive regard as long as he or she is acceptant toward him or herself in having those reactions, and is able to accurately symbolize the experiences in awareness.

   Inhibiting expression of contradictory attitudes while being able to accurately symbolize them to oneself is not incongruence. Although it is desirable that the therapist remain open to disclosing the contradictory attitudes if they persist with the client. Inhibition of the experiences of attitudes that are contradictory to the therapeutic attitudes allows the therapist to reflect on them and their stimuli and to seek consultation rather than impulsively voicing them. Therapeutically problematic incongruence involves being unaware of, but betraying in words or expressive behavior, attitudes contradictory to the therapeutic attitudes (Brodley, 1996b). There are other interpretations of congruence and incongruence. (See Lietaer, 1993).
6. Empathic understanding without therapist congruence and therapist acceptance is not what is meant in Rogers's (1957;1959) theory. Unconditional positive regard is not perceivable and/or receivable by the client if it is not infused with or coexistent with the

informedness of empathic understanding and the validating quality of therapist genuineness. Congruence as the wholeness and authenticity of the therapist may be admirable and be an ideal state, but its therapeutic potency requires its integration with enlightened acceptance which is the combination of unconditional positive regard and empathic understanding. Rogers's therapeutic attitudes are a totality – one holistic therapeutic attitude in practice.

7. Acceptant, authentic, empathic understanding is inherently a nondirective phenomenon. On the one hand, acting on agendas or goals for the client is not unconditional acceptance. On the other hand, behaving nondirectively without empathic understanding, acceptance and authenticity is not an expression of the client-centered nondirective attitude. It is more likely a passive or indifferent attitude expressed in noninterference. The nondirective attitude adheres to felt values of respect, trust, democratic and egalitarian values, the valuing of freedom. These are all active, caring values, not passive or indifferent ones.
8. In client-centered work there are occasionally responses that express the therapist's frame of reference (in addition to responses to questions and requests). There are forms of response in client-centered work which are consistent with the nondirective attitude and the other therapeutic attitudes, but which are not the direct result of these attitudes. Therapist responses which are expressed out of persistent feelings (usually aimed to correct for therapist incongruence when other avenues for correction are not effective) and spontaneous responses (Brodley, 1987), cannot be considered behavioral implications of the nondirective attitude nor of the basic therapeutic attitudes. These forms of response result from therapists needing a leeway or elbowroom that protects their authenticity as persons in relationship. Personhood is a more fundamental characteristic of the therapist than his or her therapisthood. It is an idiosyncratic component in client-centered therapeutic relationships tempered by therapeutic theory. Such idiosyncratic responses, when they occur, are shaped in part by the therapist's motivations to preserve empathy and acceptance and manifest these characteristics although they are expressed from the therapist's frame of reference. In any case, these forms of response are necessarily infrequent in client-centered work. In a sample of Rogers's work with regular clients they constitute a mean of 4% of his responses (Brodley, 1994).
9. Susan Yelton is presently carrying out research on how Rogers and other client-centered and person-centered therapists respond to their clients' questions and requests.
10. Psychotherapy is carried out in many settings having varying institutional requirements. Taking a history, doing a diagnostic history or making notes of a treatment plan, etc. when required by the institution do not preclude functioning as a client-centered therapist. One way to combine extra and counter therapeutic requirements with client-centered therapy is for the therapist to be clear about the distinction, communicate the distinction to the client and to temporarily separate the non therapeutic activities from pure therapy time.
11. It might be argued that the restrictions placed on the behavioral repertory of client-centered therapists betrays the basic principles of respect for, and trust in clients as actualizing beings. Why wouldn't clients, if they are inherently selfactualizing beings, override directive therapist behaviors and protect their own autonomies? In actual practice, some clients do just that. In fact, the evidence that all therapies often help their clients tends to support that principle. Clients often benefit from directive therapists, apparently selecting the elements of empathy, compassion, acceptance and, perhaps the modules of wisdom dispensed by such therapists to support their own growth and healing. There is no evidence, however, to give us confidence that such benefits are not contaminated within the whole person in ways that undermine the person. The issues of outcome are very

complex. Emphasis on the protection of autonomy, self-determination and self-direction of the client in client-centered work is based on the view that the reason for therapy is some degree of damage to the client's self (Rogers, 1959) which may be expressed in inadequate self-protection, in-adequate self-regulation and inadequate self-determination. Responding honestly to clients' questions, accommodation to clients' requests, and spontaneous therapist responses – any of which might risk interference in or undermine clients' vulnerable sense of self – involves a flexibility that, hopefully, compensates for the protective feature of client-centered work which might otherwise, paradoxically, undermine clients' independence and empowerment. There is no certainty about this matter. We make our choices about what to emphasize in selecting therapeutic theories as the basis for our practice. Then we observe the results as impartially as we can and modify our theory and practice if it doesn't work as we expect.

12. Raskin (1988) introduced the concept of spontaneous and non-systematic forms of response (such as the therapist offering reactions, suggestions, asking questions, etc.) in client/person-centered therapy, while maintaining the same basic respect for the self-directive capacities of the client and for the client as "architect of the process" (p 2). In Raskin's view the therapist is being systematically directive when he or she has a preconceived notion of how to change the client and "work(s) at it in a systematic fashion" (p 3).

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