

CLIENT-CENTERED: AN EXPRESSIVE THERAPY¹

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Introduction

My aim is to offer an argument for conceptualizing client-centered therapy as an expressive therapy and to suggest client-centered practitioners be mindful of this characteristic as they work with clients. The theory and the attitudes of client-centeredness, as articulated by Carl Rogers (1957;1959), can be interpreted to preclude the therapist experiencing the mental set of using means to achieve ends while doing therapy. Instead, the client-centered therapist adopts an expressive attitude while engaging in the therapeutic relationship.

Previously I have been a proponent of the interpretation of client-centeredness as intrinsically involving a nondirective attitude (Brodley, 1997; Brodley, 1987; Brodley, 1986; Raskin, 1947). Reflecting upon implications of this view and upon my own work, it became apparent to me that therapeutic activity which involves the therapist in maintaining a nondirective attitude results in an expressive rather than an instrumental practice.

The fundamentally expressive character of client-centered work, I also realized, sometimes does not appear to be understood by therapists within the client-centered or person-centered milieu when they refer to "using empathic responses" or "using the self", or "using congruence". Such statements of "use" suggest that the therapist is authentically client-centered while experiencing and employing an instrumental attitude. Although there may be rare moments when a client-centered therapist adopts an instrumental attitude and pursues a goal for the client that is conceived by the therapist, these instances seem to me to be quite uncharacteristic of the approach (Bozarth, 1993).

Instrumental Attitude

An instrumental attitude² involves a person having immediate intentions to use means to achieve ends or goals outside of him or herself. Instrumental means to choose and employ an action or other means in order to bring about a goal that is outside of, or other than, immediate expressive benefit to oneself. In therapy, an instrumental attitude involves immediate intentions to achieve ends or goals in or about the client. For example, a (non-client-centered) therapist may intend to influence a client to recognize his hostility towards his boss as a factor in his frequent tardiness for work. Or such a therapist may intend to influence a client to feel compassion and sympathy for his wife's hurt. Or may intend to influence a client to recognize her own innocence and helplessness when she was sexually abused as a child. These are examples of goals conceived by some therapists for their clients. They represent an instrumental therapeutic attitude.

Expressive Attitude

In this context, the expressive attitude refers to client-centered therapists' intentions while interacting with clients. In general, an expressive attitude³ involves immediate intentions to express meanings, feelings, desires, values or attitudes for oneself. Expression refers to "putting into words", or "showing a feeling", and it involves looks, intonations, or language that express meanings or feelings. It is an externalizing of what is internal for the sake of the expressor. A person's expressive attitudes often, although not necessarily, occur in the context of being in communication with another person or in a relationship with another person. The immediate expressive intentions, however, are for the purpose of the expression even if it is serving communicative impulses. Expression transforms what is within one's mind or feelings into language or other expressive means. The purposes of actions flowing from an expressive attitude are immediate, self expressive, self relieving or self releasing, as well as being to communicate.

Objectively Instrumental While Subjectively Expressive

My thesis is superficially paradoxical. Client-centeredness is not instrumental. It is intrinsically expressive but at the same time it is a practice intended to help other persons. As a therapy, it is designed to effect change in other persons. Consequently, in an objectively descriptive sense client-centered therapy is instrumental. It is a means to an end. Its purpose, its most general goal, is the same as that of other therapies-- to enhance the well being and mental health of clients, promote personal development, and to do these things without causing harm to clients.

Rogers' (1957) necessary and sufficient conditions for therapeutic personality change-- specifically the therapeutic attitudes of congruence, unconditional positive regard and empathic understanding-- are conceptualized as the means to these general therapeutic ends. This is a generally accurate descriptive statement about the cause-effect feature of the therapy from an objective perspective. Nevertheless, it does not accurately characterize the immediate intentions or the actual behaviors of the client-centered therapist in therapy as they may be described from the perspective of the therapist.

The practical means of client-centered therapy are the implementations the therapist creates from moment to moment in the relationship-- words and expressive gestures in interaction with the client. The issue here concerns the phenomenological reason for these implementations. My view is that the client-centered principles of respect for and trust in the client's constructive capabilities are manifested in a ubiquitous nondirective attitude. This attitude brings about implementations which are distinctly intended to express the therapist's subjective therapeutic attitudes and are distinctly not intended to produce effects in the client. Thus, the reason for the implementations is the therapist's nondirective expressive attitude intertwined with the therapeutic attitudes. The therapist wants to acceptantly empathically understand the client. The therapeutic attitudes and the expressive attitude are incorporated within the therapist's personality and brought out, or implemented, particularly in the therapeutic setting through the therapist's expressive verbal communications and nonverbal expressive behavior. The following excerpt from a demonstration therapy session I conducted several years ago illustrates client-centered behavior resulting from expressive intentions:

Client: I was thinking about my mother the other day....She and I had a very competitive relationship...(Pause) Three days ago in Budapest I saw a lady in the street who reminded me of my mother. But not at the age she has right now, but twenty years from now. I don't know why I was so struck by that. I saw my mother being old and, and weak. So she was not this powerful, domineering person she used to be in Greece, which I was so much afraid of.

Therapist: But old, and weakened and diminished.

Client: Diminished. That's the word. (**T:** Uhm Hmm) That's the word. (Begins to cry).

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

Client: Um hum. I think there was something in that lady's eyes that reminded me of my mother (Voice breaks, crying) which I was not aware of when I was in Greece. (Pause) And it was fear. (**T:** Uhm hmm) I saw fear in the woman's eyes.

Therapist: Fear.

Client: Yeah. I was not aware of that.

Therapist: When you say 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.

Client: I felt that.... That this woman needed me. (Pause) It feels good that I am crying now. (**T:** Uhm Hmm) I am feeling very well that I am crying.

Therapist: Uhm Hmm. It was a sense of your mother in the future, and that your mother will need you.

Client: That's it. In the future, not in the present. (Pause) It feels right here. (Places her hand over her abdomen).

Therapist: The feeling is that your mother will have fear and will have great need for you (C: Yeah) later on.

Client: And as I am going back to Greece, I don't know 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. (Continuing to cry as she speaks).

Therapist: Uhm hmm, uhm hmm, uhm hmm. (Pause) 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 you're not ready to meet that.

Client: That's it, yeah, and it's gotten too much for me. Or I, right now in Hungary, I perceive it as being too much. (Crying continues and session continues).

Being the therapist in the above interaction, I can testify that my intentions were purely communicative and expressive, I wanted to understand empathically and I spoke to the client in order to express what I thought I was understanding. I also felt emotionally present. From the client's and from observers' reports, my face and body conveyed that I was emotionally present.

The client-centered therapist's immediate intentions are to experience the therapeutic attitudes and to communicate in order to find out from the client whether subjective understandings are accurate. The therapist checks to find out if he or she has accurately understood the client. Checking expresses a desire to receive a response from the client. The therapist is seeking communicative interaction with the client as a means to further experience accurate empathic understanding.

Instead of being for the sake of goals for the client, the therapeutic attitudes of congruence, unconditional positive regard, and empathic understanding are being expressed in the relationship for the sake of the therapist's own expressive needs and for the sake of the therapist having further experience of the attitudes. As the therapist expresses his or her understandings and receives confirmations or corrections from the client, the therapist's empathic attitude is further enhanced and carried forward. In this way, authentic communication occurs between therapist and client because the therapist deeply wants to remain congruent, wants to acceptantly and empathically understand, while the client wants to be accepted and understood.

Acceptant, empathic responses, intended to express the therapist's own desire to understand, do produce effects⁴ in the client and on the relationship. Many of these effects are therapeutic. Desirable as they are, the effects are nevertheless incidental. The therapeutic attitudes are not communicated or expressed in the immediate moments of the interaction to promote the therapeutic effects they often evoke.

Protection of Clients' Self-Determination

From a theoretical and objective perspective the therapeutic attitudes-- the therapist's congruence, unconditional positive regard and empathic understanding in the

relationship-- are expected to create interpersonal and intrapsychic conditions which foster the growth and therapeutic change capabilities of the client. But this conceptualization does not represent the phenomenological theoretical intention nor the actual, experienced intention of the therapist in the relationship.

It may seem strange, but the therapeutic benefits of client-centered work are serendipitous in the sense that they are not the result of the therapist's concrete intentions when he or she is present with and expressively communicating with the client. The absence of intentional goals pursued for clients seems to me to be essential for some of the distinctive therapeutic benefits of the approach. Specifically, the nondirectivity inherent in the therapist's expressive attitude helps protect the client's autonomy and self-determination. It has the effect of promoting the client's experience of being the architect of the therapy (Raskin, 1987). In protecting these qualities, the approach empowers the client and strengthens inherent growthful capabilities.

Many therapies appear to help clients but, through various forms of directivity, disempower the client and at least in that way hurt or undermine the client while helping. Client-centeredness, in its nondirectivity and in its expressiveness-- being profoundly non-diagnostic and concretely not a means to any ends in the usual meaning of being means to achieve ends-- has an exceptional power to help without harming.

Objective and Phenomenological Description

The means to ends issue is confused in discussions concerning client-centered therapy when a distinction is not made between objective description of the therapy and its description from within the phenomenology of the therapist. From the viewpoint of the therapist the activity (both subjective and behavioral) of being client-centered springs from fundamental attitudes and intentions. To avoid confusion, these must be distinguished from external or objective descriptions of client-centeredness which imply instrumentality.

Consciousness of the difference between phenomenologic and objective descriptions of therapy is important because objective descriptions of therapeutic procedures tend to be interpreted as prescriptions or instructions for procedures. Prescriptions engender instrumental attitudes and intentions. Such confusions involve misunderstandings of client-centered therapy, a therapeutic approach which is already misunderstood, undervalued and underemployed in the psychotherapeutic field. Confusion and misunderstandings are promoted or not partly depending upon the way descriptive statements are worded in respect to frame of reference.

For example, a description of an important aspect of client-centered work may be stated, "empathic responses frequently communicate the empathic attitude to clients". The statement becomes misleading if it is slightly changed to say "client-centered therapists often use empathic responses to communicate their empathic attitude". This latter statement implies that from the frame of reference of the therapist empathic responses are deliberately used. Such a statement is likely to be taken to mean what is usually meant in describing therapies. That a certain technique is employed by the therapist to pursue certain goals he has for the client. Further, the statement "... therapist's often use empathic responses..." suggests a prescription or instruction to therapists and as such is misleading.

Another example. Describing the effects of client centered therapy, it is accurate to say "The client often becomes more focused on his inner feelings and his inner experiences and speaks from more depth in himself". This is a description of something that often happens in client-centered therapy. In contrast, the statement "the therapist uses client-centered therapy to focus the client on his experiences and feelings" would not be accurate. Client-centered therapists characteristically do not have any such specific goals for clients. (Some related therapies do have such goals. For example, Gendlin's (1996) focusing oriented experiential psychotherapy.) It is in this sense, of not having goals for clients, that in the existential activity of doing therapy client-centered therapists do not employ means to ends at all.

Contrasting Client-Centered with the Intersubjective Psychoanalytic Method

A contrasting approach that has theoretical and behavioral similarities to client-centeredness (Kahn, 1996; 1997) may be useful to clarify this essential nondirective and expressive characteristic of client-centeredness. In the intersubjective approach as described by Stolorow & Atwood (1992), the therapist's attitude is an instrumental one, and the therapist's actions, such as empathic understanding communications, are employed as means to facilitate therapist determined goals or ends.

According to the intersubjective approach, the therapist's behavior is based on a conceptualization of three types of unconsciousness: (1) The prereflective unconscious which refers to organizing principles which were engendered early in a person's life that shape and thematize a person's experiences. (2) The dynamic unconscious which refers to experiences that have been kept from articulation because they were perceived to threaten needed connections to others. And (3) the unvalidated unconscious which refers to experiences that the person could not articulate because they were not validated by significant others. Although these forms of unconsciousness are inter-related, each is conceived as having different specific etiology. What Stolorow and Atwood refer to as "sustained empathic inquiry", which appears to be similar to empathic understanding interaction in client-centered therapy, is a method employed by the analyst for investigating the patient's unconsciously organized experiences.

In intersubjective psychoanalytic work, in addition to empathic inquiry, different modes of therapeutic action are initiated by the analyst depending upon which of the three forms of unconsciousness are being examined in the analysis. Various modes of analytic treatment (e.g. empathic inquiry, analysis of the transference, analysis of the resistance) are means employed to effect certain specific therapist conceived goals in respect to uncovering and transforming the patient's experiences. The means selected for the therapeutic strategy of the moment depend upon the analyst's conception of the correct ends to pursue for the patient's good.

Rogers' (1959) personality theory - including his theories of congruence, incongruence, theory of the generation of psychological disturbance and the theoretical conceptualization of the personality in therapeutic change - is similar to the intersubjective theory, although not as detailed. The empathic interaction process which is characteristic of much of client-centered work is similar to the empathic inquiry method of the intersubjective

approach. In actual therapeutic work, however, there are profound differences that can be partly characterized in terms of the instrumental-expressive distinction.

The client-centered therapist makes no diagnostic or other classificatory decisions concerning the etiology of the client's problems nor decisions about what process should be optimal for the client. Classificatory decisions are not necessary in client-centered therapy because the approach accommodates to the individual and because the therapist's intentions are not mean-ends intentions. The client-centered therapist attunes him or her self to the client as a unique individual, not to the client as representative of a class or category. Consequently diagnostic and other classifications of clients or their behavior are usually ignored as irrelevant to the way the therapist relates to the client⁵.

The therapist attempts to empathically understand the client, consistently experience acceptance towards the client and maintain personal integration and accurate self-awareness while in relation to the client. When perceived by the client, acceptant empathy is thought to free the client's potential for self-healing and for the client's personal growth to occur in the unique client's own way. Classificatory considerations are thought to be an obstacle to therapists' openness to their clients. They risk the appearance (if not the reality) of not accepting or not understanding the unique person and may undermine the therapeutic relationship as it exists within the client-centered approach.

If the Stolorow and Atwood tricotomy of the unconsciousness of clients and etiology were considered to be correct and incorporated into, to fill out, Rogers' personality change theory, it would not affect the expressive nature of client-centered therapeutics. The intersubjective theoretical insert would remain irrelevant to the practice in the same way that Rogers' present conception of personality and personality change does not influence the way the therapist proceeds. This independence of the psychotherapy from the personality theory that is related to it is the consequence of client-centered therapy being based on the assumption of the actualization tendency and its implication for a nondirective attitude in practice. It is also based on ethical values concerning persons that logically and practically lead to the nondirective principle in the practice. The therapy from the top down is not designed according to a means-to-effect-ends model. The assumption of the therapy is that the therapist's acceptant empathic way of being - accommodative in its particulars to the individual client - is necessary and sufficient to free the developmental and self-healing capacities of clients.

Why There is No Confrontation in Client-Centered Therapy

According to the theory, the therapist's behavior, the implementations, must truly express the attitudes and be consistent with the values of the approach that inform the therapeutic attitudes. Certain means-ends constructions and strategies that are common in other therapies have no place in client-centered work because they would conflict with the therapist's nondirective and expressive attitudes.

We cannot, for example, confront a client in order to make him better. This would use a means that challenges the reality of the client, to (presumably) improve his accuracy of perception about something which would (presumably) be an aspect of improved mental health. The client-centered principles of respect and trust, the view that the client is the best expert about himself, the meaning of the empathic attitude, as well as client-centered

humility in respect to the perceptual worlds of others - all would be contradicted by an attitude of confrontation.

“Confrontation” means challenging another person’s ideas or perceptions from a posture of superior knowledge. The person doing the confronting thinks he or she knows the client’s truth better than the client. In contrast, if the genuine purpose of a therapist’s “confrontation” is to understand something that seems unclear or internally inconsistent in what the client has been communicating, then it is not a confrontation at all. Responses aimed to understand such material are likely to be empathic understanding responses or questions for clarification which express the empathic attitude. The attitude of confrontation is an attitude that is different from the empathic attitude expressed in an empathic response or a question for clarification. The wording and expressiveness of the statements communicating the two attitudes are different. Thus the messages and feelings perceived by the client and the client’s reactions would very likely be different because the therapist’s attitudes - expressing different concrete intentions - are different. The following interactions illustrate the difference between a confrontative and an empathic attitude.

Client: I was such a rebellious and hostile and disobedient kid. They couldn’t tell me anything that I wouldn’t go against it. (Pause) I always wanted to be a good boy, to please Mom and Dad and make them proud of me. It was my deepest wish, my deepest need.

Therapist: (Confronting) You wanted the reward of them feeling good about you, but what you wanted for yourself was to have your own way.

Therapist: (Alternatively, expressing the empathic attitude) You deeply wanted your parents’ love and acceptance. But all the time you were angry and resentful and rebellious and that defeated what you wanted and needed from them.

An empathic response may include some elements that are inferred to be within the client’s intended communication, as in the example when the therapist says “that defeated what you wanted...” But unlike the confrontative response of the example, the empathic intention involves no goal to interpret the client’s motives and does not do so unless the client appears to have intended to interpret them.

The Importance of Empathic Understanding Responses

The view that client-centered therapists do not employ means to ends, however, is not meant to imply that the behavioral methods of the therapy, or as Rogers (1951, p 24-26) expressed it, “the implementations” of client-centeredness, are unimportant. John Shlien (personal communication, 1995) has expressed the view that the practice of empathic understanding is one of Rogers’ major contributions to client-centered therapy. He asserts that we cannot adequately think of the approach in terms only of attitudes. This is because empathic understanding interaction process is intrinsic to client-centered work. In other words, there is a form of interaction that Rogers (and his colleagues) developed that is fundamental to client-centered therapy. Raskin (1947) expressed this form of interaction as follows:

There is a process of counselor response which... represents the nondirective attitude... (It) becomes an active experiencing with the client of

the feelings to which he gives expression... the counselor makes a maximum effort to get under the skin of the person with whom he is communicating, he tries to get within and to live the attitudes expressed instead of observing them to catch every nuance of their changing nature; in a word, to absorb himself completely in the attitudes of the other. And in struggling to do this, there is simply no room for any other type of counselor activity or attitude; if he is attempting to live the attitudes of the other, he cannot be diagnosing them, he cannot be thinking of making the process go faster. Because he is an other, and not the client, the understanding is not spontaneous but must be acquired, and this through the most intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention (p 2-4).

Shlien's view of the importance of empathic understanding responses in the therapeutic interaction in client-centered therapy and his view of their intrinsic connection to client-centered therapy is correct. Empathic understanding interactions are inevitable and necessary in client-centered work⁶. This does not mean empathic interaction is employed as a means to effect some goal in the client from the perspective of the subjective intentions, the attitude, of the therapist who is engaging in the interaction.

The therapist's engagement is expressive and in this manner the goal is one for the therapist's self. Although such a goal may bring to mind selfishness or coldness this is not at all the reality. When working well, and according to the ideas of the theory, the therapist is experiencing feelings of warmth, caring and generosity in relation to the client; qualities intrinsic to acceptant empathy. In addition, the therapist's maintenance of a self-oriented goal is protective of the client's autonomy while externalizing these positive interpersonal feelings.

The therapist desires to understand and explicitly communicates to find out whether or not his or her subjective empathic understanding is accurate. Empathic understanding interaction between therapist and client springs from the therapist's intentions to acceptantly and empathically understand the client. Interactively, it also springs from the client's intentions to represent himself and be understood.

Empathic Understanding Is An Interactive Phenomenon

Empathic understanding itself is necessarily an interactive phenomenon. We only have our impressions of accurate empathic understanding of clients as the result of listening to the client and subjectively translating the client's words and expressiveness into our own meanings, into our own understandings. To truly empathically understand a client it is absolutely necessary to engage in a process of checking our understandings. We rely on the client's communications in response to our checkings - the client's verifications, corrections or denials concerning our understandings and our further checkings, and so forth.

Empathic understanding as both attitude and behavior, correctly understood, is a nondirective process of interaction. It is a nondirective process partly because it is in accord with the implied wishes and intentions of the client. That is, the client is communicating in order to be listened to and accurately understood. It is highly likely that anyone engaging in a self-disclosing narrative, while talking to another person, is seeking acceptance or at least accurate understanding. This seems even more likely in the context of therapy where the

client has arrived because he has experiences that are painful or unsatisfying that he hopes to change. It seems logical and accurate to assert that clients' self-representing, communicative behavior is naturally intended to be listened to and acceptantly understood⁷. Thus the client-centered therapist has reason to believe he or she is following the voice (see Grant, 1990) or will of the client when empathically understanding.

The therapist is guided by the general theory that the attitudes of congruence, etc. create therapeutic conditions. But in the actual situation the therapist is engaging in a reciprocal interaction that is one of following the will of the client, as well as following what the client is expressing, by experientially and behaviorally empathically following the client. Rogers stated that he does not have goals for the client. His goals are for himself, to be congruent, acceptant and empathic (Baldwin, 1987). This is an extremely significant statement about Rogers' own form of client-centered therapy practice. In his statement Rogers is communicating, while avoiding a dictatorial attitude, something fundamental in respect to the basic theory and attitudes of client-centeredness. The implication is that the therapist's goals should not be goals for the client.

If we do therapy intending goals for clients we are not functioning consistently within Rogers' expressed conception of his form of client-centered practice - certainly a choice we can make or not make. In addition, if we are thinking in terms of means to ends, we may appear to be trying to understand, we may appear to be accepting, we may appear to be whole - of a single mind - in what we are doing. If we are doing what we are doing for some other purpose such as to produce an effect in the client, we are up to something other than how we appear to be. Being up to something is not consistent with the totality of client-centered values including the idea that we are not engaging in pursuing goals for the client and not consistent with the attitude that we aim to not deceive the client as to ourselves (Rogers, 1957).

Conclusion

A fundamental stance of the client-centered therapist is to act spontaneously (although it is a disciplined spontaneity) and authentically in our relationships with clients. All client-centered therapeutic behavior is intended to be responsive to the unique client and springs otherwise primarily from the therapist's immediately experienced attitudes and values. In this way of being in the relationship, the therapist is attempting to relate to the client authentically. And the therapist is acting consistently with Rogers' (Baldwin, 1987) statement:

...therapy is most effective when the therapist's goals are limited to the process of therapy and not to the outcome...." I want to be as present to the person as possible. I want to really listen.... I want to be real in this relationship", then these are suitable goals for the therapist (p 47).

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¹ An “expressive therapy”, in this paper refers to the personally expressive intentions of the therapist while relating to clients in client-centered therapy. It should not be confused with the Expressive Therapy approach developed by Natalie Rogers (1985) in which creative activity such as dance, painting and other arts are employed for therapeutic goals.

² It is apparent that an instrumental attitude, while immediately focusing outside of oneself, often results in ultimate benefits or disadvantages to the person acting out of the attitude. One writes a resume to persuade a potential employer that one is right for the job. If this instrumental action is effective, the person benefits by getting the job.

³ An expressive attitude focuses immediately on the expression itself, but the behavior may have effects outside of the self. The victim screams expressively out of terror, but the scream may bring help.

⁴ Some of the therapeutic effects produced through nondirective, acceptant, empathic understanding are: a sense of being understood; a sense of safety in relation to the therapist; a sense of being accepted with all of the client’s feelings and reactions; the experience of more immediate and real feelings; the experience of insights and new self understandings; and in general, various personally productive self-changing processes.

⁵ Diagnostic and other classifications of clients are not needed for client-centered work unless referrals are being made for the client to benefit from other services. Examples of other services that might require at least tentative diagnostic or other classifications of clients are medical (psychiatric or physical), educational, or specific psychotechnological treatments such as relaxation or cognitive techniques, and for insurance purposes.

⁶ An exception is working with a silent and hospitalized client. The client-centered therapist in that situation is likely to make empathic guesses based on his familiarity with the client’s immediate situation (Rogers, 1967). Responding to clients’ questions also involves other forms of response in addition to empathic understanding (Brodley, 1996).

⁷ Therapists are wise to assure their clients at the outset of therapy that they are free to ask questions and that the therapist is willing to answer questions. In addition to the benefit of freeing the client from wrong, inhibiting assumptions, it gives the therapist some reassurance that the self-representing, narrating client is wanting to be listened to and wanting to be understood - not wanting something else while we are empathically following.

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