

# EMPATHY TOWARD CLIENT PERCEPTION OF THERAPIST INTENT: EVALUATING ONE'S PERSON-CENTEREDNESS

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**ABSTRACT.** *Evaluating one's own person-centeredness can be facilitated by asking the question, "What is the client's perception of the therapist's intent." The present paper asserts that from a person-centered approach, the client's perceptual stance is the context for relationship development, and a context within which the therapist's response must be evaluated. Empathy with the client's phenomenal world of the therapists' intent can be a guide for evaluating therapeutic person-centeredness. To assure that the therapist manifests a trust in the client's self-actualization tendency, it is critical to assess the client's perception that this is so.*

The hallmark of evaluating person-centered therapy has traditionally been assessing therapist intent. When judging whether one's therapeutic relationship with a client falls within the domain of person-centered therapy, the veteran will query, "What was the therapist's intent?" The purpose of the present paper is to demonstrate that a second question, "What is the client's perception of therapist intent," can also be used to supplement the question of therapist intent in creating a more global evaluation of the person-centeredness of the therapeutic relationship.

A summary of why intent is critical in evaluating the person-centered approach would reveal such elements as whether the therapist intended to understand the client (consistent with the approach), intended to make the client aware of their incongruity (inconsistent with the approach), intended to accept the client's statements as valid for him or her (consistent with the approach), intended to get the client to see the situation from an alternative perspective (inconsistent with the approach), and so forth. The question of intent is critical for evaluating a person-centered response. Intent is a useful question for evaluating the consistency between one's response and any theoretical model.

The PCA therapist believes in the formative tendency and the concomitant actualization tendency; and hence the underlying assumption of the client as her or his own best expert. It is this belief in client expertise that distinguishes the PCA from other therapeutic philosophies. When the PCA therapist evaluates their responses to clients, they therefore must consider not only their own intent, but the clients' perception of that intent- since the phenomenological world

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of the client is the reality within the therapeutic relationship that is more central than is the phenomenological world of the therapist. In other theoretical models, the therapist's phenomenological world (of expertise) takes precedence in defining the course and progress of therapy. From a PCA, the client's perceptual stance is the context for relationship development, and the context in which the therapist's response must be evaluated.

Client-Centered Therapy originated within a framework that viewed client response to therapist response as the key to understanding what works in facilitating the client's actualizing tendency. Recorded interviews enabled Rogers (1942) and his students to listen to their intentions within the context of the client's perceptions of their intent. For instance, client defensiveness provided a cue that the therapist had issued judgment, confrontation, or some other response not consistent with client-centeredness.

A person-centered therapy grows through the therapist's willingness to be empathic with the client's perception of the relationship, more than through the willingness to bring his or her own perceptions into the relationship. In other words, person-centered therapists bring themselves into relationship within the client's world, and only occasionally may feel the need to bring the client into their world. And this is not as though the real person of the therapist is absent from the relationship-it is that the therapeutic relationship is a special instance of relationship where the client's phenomenal world is the central context for being in the relationship, unlike friendships or love relationships, where two viable perceptual fields provide the ongoing context for growth.

Spahn (1992) describes this focus on the client's perceptual field in a memory of Rogers being "totally focused on the other person" (p. 33). He further proposes that a healing relationship is characterized by an "exclusive focus of loving attention [where] . . . separateness [gives] way to unity. . ." (p. 34). The presence of the therapist whose attitude is one of openness to unity with the client is a presence that suspends, even if momentarily, the as-if condition, to give way to the creation of something wholly different than the sum of its parts. "Unity" as a construct encompasses "the state of being one; singleness," and "the combination or arrangement of parts into a whole; unification" (*American Heritage Dictionary*, 1985, p. 1,322).

Barrett-Lennard (1981) is vigilant of these two qualities of unity when speaking of *The semi-autonomous phases of empathy*. Regarding the more commonly understood meaning of empathy, he refers to a "resonation. . . [of] . . . life-to-life meeting, such that I (as client, for example) am no longer addressing you (e.g. as 'the therapist') but my experience and the me that is experiencing are alive for you, a living other self touching your own living self, with the you and the me distinct in our engaged complementarity" (p. 8). Barrett-Lennard then passes from a complementary unity into a single-minded unity in proffering "preliminary empirical evidence . . . suggesting a generally very modest association between the way others see us responding to them. . . and how well we predict that they will see and describe us" (p. 11). Watchful of the client's perceptual field, Barrett-Lennard explores the concept meta-empathy, which "is concerned with A's awareness of how B is taking A's response; in particular, in the sphere of empathy related experience and action" (p. 11-12). The emergence of something wholly new arising within the sum of its individual parts appears to rest on an openness of the therapist to the clients' perceptual field. States Barrett-Lennard:

It is the extent of A's *in-touch-ness* with how they are getting along from B's *point of view* (my italics), over a major band of their interactive/relationship spectrum. In this realm, it gets at their relationship *system* from the inside; for it is not one partner's view of one partner's response but the convergence between (i) A's view of B's perception of something happening between them-effectively, a feature of their twosomeness- and (ii) B's actual perception of the same something. (Barrett-Lennard, 1981, p. 12)

Relying on the client's perception to guide the therapeutic relationship no doubt raises fears of losing one's own (self-actualizing) intention. Questioning client perception of therapist intent relies on an external, empathic (with the client) self-evaluation that on the surface appears inimical to the PCA. Surely, just because it was not perceived does not mean I did not intend it. Human subjectivity practically necessitates that there will be gaps between how an intention is perceived. Nevertheless, while tales of losing the as-if quality are cited to exemplify the exigency of maintaining an as-if condition, they are told with a sense of reverence and awe, with the implication being "I believe, that a loss of the as-if condition is the purest condition of empathy, and that the closer one can get to embracing the client's phenomenology, the closer one is to the purity of the approach." If responses to one's client are to be evaluated for their consistency with the assumptions and core conditions of the approach, then the client's perception, not only therapist intent, must be assessed.

An emphasis on client perception of therapist attitudes and actions as a key determinant for deciphering what is important in the therapeutic relationship was identified by Rogers in his review of research on characteristics of the helping relationship. Regardless of therapist orientation, clients perceived their therapists as helpful to the extent that they felt understood, cared for, and were respected for their own values and goals. Rogers summarizes this research by saying that the therapist's attitudes and feelings are more important than their theoretical orientation, procedures and techniques, and that furthermore, ". . . it is the way in which his attitudes and procedures are *perceived* which makes a difference to the client, and that it is this perception which is crucial" (Rogers, 1958, p. 9).

Without abandoning the as-if quality the therapist empathy with client perception will come to understand the relationship between himself and the client more fully than if the question of intent is asked without regard for the client's perception. This is an especially useful approach for the beginning therapist, as well as the veteran challenged with a client experienced as "difficult."

Although client perception cannot solely answer the question of therapist intent- it can partly help to answer it. I may intend to understand my client, but be perceived by him or her as attacking. For example:

**Client:** *This place sucks. Everybody is in your business.*

**Therapist:** *You're fed up with people who won't mind their own business.*

**Client:** *Are you trying to make a fool out of me?*

**Therapist:** *No, I'm sorry, I was trying to see if I understood what you were saying.*

**Client:** *You're just like everybody else.*

In this brief scenario, the therapist reflects upon his or her intent and considers it to be, on the surface, consistent with the PC approach; yet when reflecting upon the client's perception, the therapist determines that the response was perceived as an attack upon the client's integrity. The therapist at the evaluative moment (whether during or after the session) does not conclude that there is nothing that can be done but to continue to try to respond in the usual manner, and hope that the client will eventually come to experience the therapist as accepting and understanding. Instead, consideration of the client's perception that he or she is "just like everybody else" helps them to hear now more deeply, that the client may have meant "this place sucks, everybody is in your business. . . and I hope that you won't be like everybody else." In future sessions with this client, the client's pressing need for the therapist to maintain considerable distance and allow the client to not disclose of himself or herself turned out to be central.

In another instance, the therapist tries to *offer* a psychology student client self expertise when the client clearly views the therapist as more of an expert. In this scenario, the therapist evaluates

that despite introducing a behavioral technique, the primary posture was person-centered as the client's position was honored:

**Client:** *I was thinking that you might know of some technique that I could do so that I would stop saying these negative things to myself.*

**Therapist:** *You'd like to be able to just stop saying negative things altogether.*

**Client:** *Yes, well, I know that's probably not possible, but maybe there's some kind of behavioral approach that you could teach me that would help.*

**Therapist:** *Well, I don't typically use a behavioral approach, but there is a technique I could tell you about called thought stopping which cognitive behaviorists use and some people have found helpful in reducing negative thinking.*

**Client:** *Anything that might help.*

**Therapist:** *According to this approach, (therapist explains rationale and technique including covert self talk after the thought interruption).*

**Client:** *Well, I think that the negative thoughts come from my negative self view, so I may first have to change my self concept. I doubt that this would work unless I made some changes in my self concept.*

**Therapist:** *I understand what your saying, but, from the behavioral perspective, your self concept will change as a result of what you say to yourself, so that after giving some positive statements a chance to be heard, you'll begin to believe them.*

**Client:** *(Looks at therapist like this idea is incredulous).*

**Therapist:** *But you seem to think it will be important for you to feel differently about yourself before you think differently.*

**Client:** *Yes, I think that's true.*

For this client, a brief transition into a behavioral model demonstrated the therapist's willingness to honor the client's desire to explore behaviorism as a possible source of relief for the negative self thoughts. It additionally provided a trust in the client's self-directedness, and a respect for the academic exploration of other therapeutic models.

As a scientist, Rogers insisted on verifying his hypotheses about change through repeated observations. The validity of the therapist's applied belief in the actualization tendency can only be assessed through repeated observation and evaluation. Rogers was of the opinion that "...there can be no substitute for the continual checking back and forth between purpose or hypothesis and technique or implementation" (Rogers, 1951, p. 26). He further states:

This analytical self-checking in the counselor may verbalize somewhat as follows: As I develop more clearly and more fully the attitude and hypothesis upon which I intend to deal with the client, I must check the implementation of the hypothesis in the interview material. But as I study my specific behaviors in the interview I detect implied purposes of which I had not been aware, I discover areas in which it had not occurred to me to apply the hypothesis, I realize that what was for me an implementation of one attitude is perceived by the client as the implementation of another. Thus the thorough study of my behavior sharpens, alters, and modifies the attitude and hypothesis with which I enter the next interview. A sound approach to the implementation of an hypothesis is a continuing and a reciprocal experience. (1951, p. 26)

It is harder to rationalize techniques as person-centered in intent when the therapist shifts the locus of evaluation to the client's perception than when examining therapist intent only. Developing an empathy with client perception is really synonymous with a way to be more empathic, and to more fully understand one's own intent. The novice therapist, especially, may reason that his or her action was intended to "give the client what he seemed to need or want." However, what the eyes of the therapist may not see, the eyes of the client may reveal. Upon evaluation of client perception, the therapist may discover that the responses disguised as, for example, empathic, may be experienced by the client as patronizing, protecting, condescending, psychotherapizing, and so forth. For instance, in the name of person-centered intent, one therapist shared the following interaction:

**Client:** *I don't drink during the week, just weekends.*

**Therapist:** *And you don't see that as a problem?*

**Client:** *Not really, I know a lot of people that drink more than that, and besides, I don't drink every weekend.*

**Therapist:** *So you're saying that because other people drink more than you, you don't have a problem.*

**Client:** *Well, not that they drink more, not because they drink more, I just don't think that I drink all that much.*

In evaluating the responses, the therapist maintained that the approach taken was person-centered because he or she intended to understand how the client viewed the drinking, that he or she "accepted the client's denial," and that the "challenge of the client's rationale was intended to allow the client to hear their incongruity so that they could be the judge of how honest or defensive they were being." When asked to view the client's perception, the therapist was able to see that the client probably viewed the therapist as doubting his or her sincerity, not accepting the interpretation of the client's behavior, and having a level of expertise about the client's behavior that the client did not himself or herself possess. An alternative interaction more consistent with the approach might have been for the therapist to express genuine concern about the amount of alcohol the client was drinking, and (if really strongly felt), to share that from experience, certain predictable problems occur with that drinking pattern. Thus this would present the therapist's own experience of how problem drinking develops without presuming that the client will also perceive their own behavior this way.

A therapist may be tempted to embrace the notion that the PCA focus on attitude v. action is an open invitation to act in any manner. However, only actions consistent with a core belief in a fundamental actualization tendency- where the client is their own best expert are agreeable with the person-centered approach. Even robust assumptions, which can withstand violations, should not be deliberately violated. Say Mearns and Thorne (1988), "We are little short of horrified by the recent proliferation of counselling practitioners, both in America and in Britain, who seem to believe that by sticking the label person-centered on themselves they have licence to follow the most bizarre promptings of their own intuition or to create a veritable smorgasbord of therapeutic approaches which smack of eclecticism at its most irresponsible" (p. 2).

Bozarth's (1984) exposition on the many forms that empathy may take signifies a high regard for the variegations in experience and expression that define the context of a therapeutic relationship. But what of actions, such as confrontation, which are prima facie and a priori inconsistent with the person-centered approach. Might these be available to the therapist as relational forms consistent with the approach? In an effort to resolve the question of confrontation, Lietaer (1984) posits that confrontation can co-exist within the parameters of unconditional positive regard for the client's self/experience when the confrontation is based on the behavior rather than the self, and that confrontation can co-exist within the parameters of therapist

genuineness. However, this view presumes that the client experiences his behavior as distinct from himself, and/or that the therapist has some knowledge about the client's behavior-self incongruity that the client does not himself or herself possess, and which is in the client's best interest to know. In an attempt to reckon confrontation within the PCA model, Lietaer acquiesces that "the distinction I am trying to make between person and behavior is, however, not always felt by my client. Sometimes she feels rejected as a person even if this is not the case in my experience" (p. 57). He concludes that his rule regarding the basic attitude inspiring his client-centered interventions is, "...being continuously in touch with the way in which my client experiences the confrontation and responding to that" (1984, p. 57). An empathic perception of the client's phenomenological view of confrontation as rejecting, it would seem, would lead the therapist to not use confrontation if it is the therapist's intent to maintain a person-centered stance. In the words of Cormier and Hackney (1993, p. 47), empathy is "a *communication state*. . .that . . .has no impact on the counseling process if the client does not recognize that you are empathic." It would seem that the same could be said of unconditional positive regard and genuineness.

A focus on enhancing the therapeutic relationship by considering client perception versus therapist intent is exemplified in the supervision process. In a class discussion of whether it would ever be consistent with the person-centered approach to point out that a client's non-verbal behavior is incongruous with their verbal behavior (e.g., laughing when speaking of a painful circumstance), one student advances that their intent would be to see if they understand the client. They role play as an example:

**Therapist:** *I've noticed now, after several sessions that we've met, that you often laugh when you're describing these painful experiences. I'm wondering what that means for you.*

When the other students' perceptions were queried, one student stated that the response reminded her of what once really happened to her in therapy. When her therapist observed that he noticed this incongruity, she felt awkward, and when he stated that he had known this incongruity to exist for some time, but was only now pointing it out, she felt deceived. She felt inexplicably exposed, and wondered, had he kept this secret from her until he felt she could handle it? Now the student/therapist could reassess her intention with the client's perception in mind. She now considered that she probably had waited not because she didn't have a prior understanding of the laughter, but because she wanted to have a better relationship with the client so that the client would be ready to hear it (an expert on when the client is sufficiently developed to disclose such observations). Further, the incongruity was pointed out because of the therapist's belief that the client would be in some way better off if she would be able to express pain without laughing. The judgment was not consistent with unconditional positive regard. The question of intent was thus answered more accurately through considering the client's perceptual field.

In another supervision where considering client perception facilitated therapist evaluation of her person-centered qualities, a student/therapist working with a 13 year old male offender knew that the youth feared that his mother would not be given custody of him.

**Client:** *I'd like to see her more (pause) She was gonna get her car fixed so she could come pick me up, but then she didn't (sounded disappointed and a bit discouraged and angry).*

**Therapist:** *You're kind of upset with her that she didn't get the car fixed so she could see you?*

**Client:** *Well, not really. I know she's on a tight budget. She would have come if she could've.*

**Therapist:** *I understand if you're afraid of sharing your feelings, but you don't need to be afraid because what you say to me stays between us. I know that's different than the other people here who talk to you.*

**Client:** *I know, but I wasn't really upset, I just miss her, that's all.*

The therapist's intent was originally described as a way to let the youth feel understood, and a way to clarify her role. When evaluating the client's perception, the therapist believed that the client perceived her to be caring, but not very understanding. She could have stated: "you really do want to spend more time with your mom." Moreover, the therapist now realized that in trying to "make" her client feel safe, she conveyed a lack of acceptance of keeping certain feelings secret. With this reflection, the therapist decided that she might have expressed an understanding of the boy's reluctance to disclose, and a clarification of her role, but without a suggestion that he need not be afraid.

Bozarth maintains, using a parallel with Aikido, that the client's trust of self and of the therapist often results in more embodiment of trust for the therapist. More his point, is that the more the therapist trusts the client, the more confident the client is in his or her own trust of falling without harm. "I prefer to say that the client perceives the conditions and trust that exists in the therapist" (J. D. Bozarth, personal communication, March 9, 1994). To assure that the therapist does indeed manifest this trust, it is critical to assess the client's perception that this is so.

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