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HUMILITY AS AN IMPORTANT ATTITUDE IN OVERCOMING A RUPTURE IN THE THERAPEUTIC RELATIONSHIP

Ladislav Timulák
Comenius University Bratislava, Slovakia

ABSRACT. This paper depicts the therapist's share of possible ruptures in the client-counselor relationship. It presents an attitude toward these ruptures which can facilitate the therapeutic and the client's process. It distinguishes two kinds of rupture: unspoken rupture which can be discovered by the therapist without the client's explicit pointing at it; and explicit rupture which is expressed by the client. The most important feature of the paper is the presentation of a specific therapist attitude—that of humility--which when held onto by the therapist can facilitate using ruptures for therapeutic goals. The attitude of humility towards ones own imperfections as a therapist, and towards the client's view of the therapeutic relationship and therapy is developed through description and exemplification.

The Problem

Psychotherapy is considered to be a place where interpersonal learning occurs. Despite the fact that person-centered therapy uses the therapeutic relationship as a vehicle for client change in therapy, the nature of interpersonal interaction is not often explicitly examined in the person-centered framework. With a few exceptions (see van Kessel, Lietaer, 1998), interactional processes are mostly limited to a description of the facilitative therapeutic conditions as defined by Rogers (1957).

In the field of psychotherapy it is primarily psychodynamic therapies that stress interpersonal learning in working through transference and countertransference in therapy. Psychodynamic therapy uses the interpersonal pattern, developed in the course of the therapy between the therapist and the client, as a vehicle for interpreting other important client relationships. The client's interpersonal patterns are usually viewed as transference reactions reflecting possible pathology in the client's functioning. Provision of a corrective emotional experience, with insight and emotion, is then regarded as therapeutic. These interpersonal

patterns are often characterized by high intensity in and possible threat to the therapeutic relationship. Relationship problems in person-centered therapy, on the other hand, are rarely cited in the person-centered literature. When they are, they mostly refer to deficits in providing the therapeutic conditions of empathy, unconditional positive regard, and congruence. Working through transference/countertransference is not recognized to be an important process in person-centered therapy. According to Rogers (1951), the client's expressions concerning the therapist are responded to by the therapist in the same way as other client concerns. He states, "The client-centered therapist's reaction to transference is the same as to any other attitude of the client: he endeavors to understand and accept" (Rogers, 1951, p. 203).

It is not unusual for person-centered therapists to experience problems in their therapeutic relationships. Indeed, the theoretical formulations of Rogers (1951) and others (Brodley, 1997) that emphasize the necessity of a high degree of empathy, congruence, and acceptance for the therapeutic endeavor, can paradoxically negatively impact therapists' expressions of the core conditions. High expectations set the stage for an impossible achievement-- to be fully empathic, accepting and genuine. Fears that one will be negatively judged by colleagues for failure to adequately embody the core conditions (to achieve these high expectations) contribute to therapists' denial of self-experiences, particularly where difficulty accepting clients is concerned. Verbal expressions can sometimes provide clues to a therapist's difficulty with acceptance, as in, "I feel quite comfortable with this *strange* client." Here, the client is seen as a source of uneasiness in the relationship despite the therapist's lack of insight into the judgment. I believe that this sort of denial, or incongruence regarding ones optimal therapeutic functioning, is quite common in the work person-centered therapists.

Nevertheless, sensitivity towards and awareness of the three postulated therapeutic conditions makes the person-centered therapist *generally* more acceptant, congruent and emphatic than therapists of other orientations. I remember my wife's experience when she was doing her master's thesis on client-centered therapy. One reviewer, who recognized herself as a psychodynamic therapist, mocked the part of the thesis that described client-centered therapists providing unconditional positive regard. My wife was asked, in written evaluation, whether she thought that client-centered therapists are less conditional than therapists of other orientations. We were both convinced that the answer is: generally, yes. The expectation that person-centered therapists strive toward living the core conditions in therapy implies that relationship problems between therapist and client stand a good chance of being the "fault" of the therapist. Psychodynamic therapies also confirm possible therapist contribution to therapeutic relationship problems (cf. Thomä & Kachele, 1987). Psychotherapy is considered to be a mutual process where all matters are both the therapist's and client's business.

In the following pages of this article I depict possible ruptures in the therapeutic relationship, focusing particularly on the therapists role in creating and attending to these ruptures. An attitude toward these ruptures which can facilitate the therapeutic and the client's process is presented. Two kinds of rupture are delineated: a) unspoken rupture which can be discovered by the therapist without the client's explicit pointing at it; and b) the explicit rupture which is expressed by the client. The therapist attitude of *humility*-- towards

ones own imperfections as a therapist, and towards the client's view of the therapeutic relationship and therapy-- can facilitate using ruptures for therapeutic goals.

Hidden Therapeutic Ruptures

By hidden therapeutic ruptures is meant problems with the therapist's congruence, acceptance, and empathy; or problems with the client's perception and reception of these therapist qualities without open acknowledgment of them in the therapeutic relationship. First to be discussed are hindrances on the therapist's part.

Hidden rupture in the therapist's experiencing

It is not uncommon for therapists to speak badly of difficult clients-- without, of course-- their being present. Some therapists consider doing so a form of psychohygiene. For me, this behavior indicates the therapists inability to be their ideal therapeutic self in the relationship with the client. Incongruence creates a pressure to disclose. Recognizing that one feels uncomfortable with a client is difficult in part because of the effort spent being helpful. Conscious endeavors to be facilitative can mask problems of discontentedness when with a client. During supervision, Rogers (1961) used to ask his colleagues whether they feel good with a particular client. If they did, then everything was fine, if not, they started to explore the therapist's experiencing of the relationship. Each feeling of uneasiness with the client could potentially signal ones incongruence, or at least hint at nearby vulnerabilities. We can recognize this incongruence when a therapist offers detached judgments; for instance, claiming that the client is not mature enough, not intellectually developed enough, too psychopathic, too old for a change, too overwhelmed, and so forth, to undertake the therapy. Therapists' fears of clients can signal another kind of problem. A therapists fear of being personally or professionally damaged by a client can be connected with concerns about a client's pathology and possible deterioration during the therapy, and consequently, the therapists fear of failure.

Below the surface of perhaps the majority of labels and judgments resides the therapist's problem accepting a client. Instead of recognizing their lack of acceptance, the therapist couches their intolerance toward a client's values or behavior as client pathology. But judgments serve to protect the therapist rather than to facilitate client growth. Issues that might be worked through for the benefit of the therapeutic relationship and perhaps also for the client's growth are ignored. For Rogers, acceptance was crucial. He said that the client can grow only in those aspects of self which are being accepted by the therapist.

> It has been my experience that when my attitude is conditional, he [the client] cannot change or grow in those respects in which I cannot fully receive him. And when - afterward and sometimes too late - I try to discover why I have been unable to accept him in every respect, I usually discover that it is because I have been frightened or threatened in myself by some aspect of his feelings. If I am to be more helpful, then I must myself grow and accept myself in these respects. (Rogers, 1961, p. 54)

Rogers clarifies that acceptance cannot be achieved only through its "outer" characteristics. He says:

> I used to feel that if I fulfilled all the outer conditions of trustworthiness-keeping appointments, respecting the confidential nature of the interviews, etc. - and if I acted consistently the same during the interviews, then this condition would be fulfilled. But experience drove home the fact that to act consistently acceptant, for example, if in fact I was feeling annoyed or skeptical or some other non-acceptant feeling, was certain in the long run to be perceived as inconsistent or untrustworthy. I have come to recognize that being trustworthy does not demand that I be rigidly consistent but that I be dependably real. The term 'congruent' is one I have used to describe the way I would like to be. (Rogers, 1961, p. 50)

This quality of being, which Rogers sometimes calls "realness," or "presence" (see e.g. Rogers, 1967), is an important precondition for being facilitative with a client. Striving for this quality requires recognizing my uneasiness with a client and subsequently exploring my personal concerns. Recognition of the part of my self (my specific values or attitudes, together with their developmental history) which is challenged or activated by an interaction with the client can help me to recognize whether this part of my self really needs to be reformulated or whether I want it to remain constant for my sense of safety. If safety is not considered imperative, I can transform my self within the ongoing interaction.

Uneasiness in relationships with clients thus challenges personal growth. Looking inside oneself is salutary even if, especially in cases of fear, one decides not to change. At least I can more closely touch the values in my self which serve as my core internal order important for my well-being. As I am in touch with my self, I can be more congruent with the client, I can be closer to my real, although imperfect self (imperfect in a sense of not being theoretically optimal). When I am deeply my self, I either recognize that a) I can accept the client because my uneasiness might be my vulnerability which I want to overcome (i.e. grow in this aspect); or b) I find that this hardly acceptable aspect of the client interferes with my core self which I want to be. In the latter I can open the issue for a discussion into which I enter explicitly with the possibility that I might be changed through the "real encounter." I open the issue not because I want to solve it, but because it can potentially enrich the therapeutic relationship and the client. Thus I either become more congruent through my internal effort, or through disclosure and preparedness for a mutual exploration of the issue.

The conscious attitude of humility towards one's own imperfection and responsibility (because it is not the client who is responsible for my experiencing) can be useful in recognizing that my concerns interfere with acceptance of the client. With an attitude of humility I am more prepared to recognize my contribution to uneasiness in the relationship with the client. This does not mean that I should feel guilty for my non-acceptance. On the contrary, humility helps me to admit that limitations in my capacity to accept others are elements of a normal human functioning. Rather than criticizing and blaming myself, I prefer to be full of humility towards my self, including my imperfections (and too the client's).

Willingness to accept imperfections as a therapist (humility) can strengthen congruence--or at least attentiveness and sensitivity to congruence. This attitude diminishes my proneness to self-defense. If my attitude of humility is real, then I am open to listening to myself. Also, if I am full of humility towards my client, in the sense that I deeply respect the client and that I take the client's experiencing, verbalizing, and behaving as something that the client might need for her or his growth, then I am more unlikely to defensively judge and pathologize the client. Thus I am more prepared to enter into encounter with that person.

I mentioned previously two possibilities for handling uneasiness which may be aroused in me as a therapist, 1) internal work; and 2) disclosure with preparedness for an encounter. Regarding the former, I remember having a problem listening to the complaints of a really unhappy woman. I was about to tell her that it was not surprising the me that she was so desperate when she behaved (complained) the same way with everybody. Fortunately I did not say that, but instead focused on myself and started to listen to what it was in me that made me feel so uncomfortable. I heard my own similar experiences when some women treated me as did she with significant others. As I comprehended my turmoil, my prejudice suddenly abated and I was then able to sense her despair. I felt more comfortable (more congruent) in our relationship—able to really put myself into her shoes. The more I understood and accepted my self, the more I accepted her. I even felt more empathic toward people with whom she reported having problems.

The attitude of humility towards personal imperfection can facilitate a conscious process involving self-focusing leading to issue resolution. It is a difficult attitude to sustain because confusion (incongruence) regarding and denial of the origins of personal misery go hand-in-hand with ones uncomfortable feeling during and/or following the therapeutic encounter. Patience and effort may help. Internal mastery over uneasiness often permits deeper understanding of the client's way of being (I am free to discover what in the client's behavior contributed to my uneasiness and thus I can enhance my empathy (see e.g. Keil, 1996)).

If no change occurs after the internal exploration of uneasiness, the therapist has an option to open the issue in front of the client. Rogers (1966) preferred letting the client know any "persistent" feeling of the therapist. Lietaer (1984; 1993) proposed several rules for such "confrontation," including those pertaining to timing, self-revelation without imposition, distinctions between the concrete behavior and the person, and being continuously in touch with the client's experiential response to a confrontation. A possible benefit of the attitude of humility is that the humble therapists' confrontations may be perceived as non-threatening by the client. If I am really humble toward my self and the client, then I bring up my uneasiness as mine—as stemming from my own imperfections regarding my facilitative capacity. When I feel genuine humility towards my imperfection and the client's way of being, my uneasiness is disclosed in the context of a willingness to change the aspect of my self which had been challenged by the client. This willingness to change is a precondition of the encounter as it was proposed by Buber in his dialogue with Rogers (see Kirschenbaum & Henderson, 1989). To illustrate, I once had a problem following a client, a university student, who continuously complained about his teachers at the university. I internally doubted that their imperfection was of the kind the client was describing. These complaints were his main topic, and in his eyes the only source of his dissatisfaction. I tried to humbly reveal my uneasiness as follows: "I am really sorry that I have a problem following you 100 percent of the time because I

continue having doubts whether the teachers are so bad... the doubts keep rising within me. What do you think about this concern of mine?" Although he was shocked from my disclosure for the moment, it made our interaction more vivid and I believe more meaningful for both of us. The attitudinal quality of humility rather than the specific words spoken is, of course, the important element. If humility is congruent, the client can "hear" it from my voice and/or my non-verbal behavior (this is not to say that sensitive communication skills do not relate to perceived trustworthiness). Through my revelation I strove to overcome the rupture aroused in me, I became more open for the client, and I also grew more prepared to encounter him. If I am congruent in my humility then it is quite probable that my disclosure will be perceived as being constructive. Even if not, humility can help me to accept it and continue to strive for the relationship. As Rogers puts it: "I am far more able to hear the surprise, or perhaps the hurt...because I have dared to be real with him [the client]" (1966, p. 185).

Hidden rupture in the client's experiencing

Hidden therapeutic ruptures are those ruptures experienced but not directly communicated by the client. Although the therapist may be congruent, empathic and acceptant to a degree perceived as sufficient by most clients, it may happen that in the context of a client's current mode of being, the therapist is perceived as failing to meet these conditions. Research shows that this event is quite common, and that clients defer to therapists due to their vulnerability in the relationship (Rennie, 1990; Rhodes, Hill, Thompson & Elliott, 1994). Therapists are usually not aware of clients' negative evaluations, and when negative evaluations are addressed and not worked through, they can lead to a breakdown in the therapeutic relationship (Rhodes et al., 1994).

How can therapists address something about which they are not aware? The therapist can simply presuppose that a client is prone to experience uneasiness in the relationship (the very nature of the therapeutic relationship leads to it), and that a client will not dare to express this uneasiness directly. The therapist can explicitly check how the client experiences the ongoing relationship and their mutual work. These checks can be done globally, for instance, "How do you feel with me?; How do you feel about our work together?", or more concretely, "Am I right?; What is your perspective on it?; I don't know how it is for you what I have just said; Maybe you meant something else; You maybe disagree with me inside; Maybe it is hard to speak about such things with me," and so forth. There are a number of ways to address a client's deference. Therapists must expect that a client will not be very precise in answering these questions because the client does not dare to challenge the therapist, or because the client is not fully aware of his or her deference.

An attitude of humility towards ones imperfection and towards the client accepts that one does not reach (optimally facilitate) every client in every moment. Willingness to acknowledge the possibility of missing something in the relationship can be the first step to not losing anything. Humility towards the client presumes that negative evaluations of the therapy or the therapist are real, and are based at least to some extent on the therapist's failure. The therapist who bears this attitude is likely to be perceived by the client as having humility at some moment (perhaps especially during the interpersonally problematic moments of the therapy). If the client perceives that the therapist values the client's point of

view and even admits his or her own share of the client's uneasiness in the relationship, then the client's disclosure is more readily released and encouraged. Through humility the therapist implicitly communicates that the client's uneasiness is a natural part of their interaction, that the therapist estimates all feelings of the client as potentially constructive, and that it is always valuable to try to resolve the issue without looking for a winner in the battle.

Congruently applying this attitude can serve therapists in many ways. First, they might be less shocked by a client's disclosing a problem regarding their relationship or work together because the therapist will not expect invariable success. This attitude elevates the probability of therapists checking client perceptions of ongoing therapeutic process, and increases sensitivity to and transparent expectations of problems in the relationship.

Working Through the Open Therapeutic Rupture

By open therapeutic ruptures I mean the client's explicit disclosure of an interpersonal problem with the therapist. There are different qualities and quantities of an open therapeutic rupture. It can go from small doubts regarding whether the therapy helps, to accusations of therapist abuse. It is also possible that a rupture is seemingly positive (erotic demand of the client) or negative (the accusation of the therapist's abuse of the client). What these ruptures have in common is that they can be potentially threatening for the stability of the therapist and his or her facilitative presence with the client, and also that they express the client's dissatisfaction with the therapist or therapy (or in the case of erotic demand that they express the client's wish to change the nature of therapy into a substitution for life outside of therapy).

Two basic alternatives exist when therapists experience a rupture. In the first case, the therapist does not take a rupture as a threat to the relationship. Thus, even if the therapist is accused or admired, congruent empathic acceptance of the client's self-experience in the context of the client's internal dynamics is not disturbed. In the second case, the therapist experiences a problem within the self when responding to the client's sense of rupture (including erotic demands/desires to use therapy to satisfy personal needs). This therapist response to a rupture is considerably more problematic (more will be said on this later). However, even if the rupture pertains to a problem within the therapist, the humility processes that facilitate using rupture for therapeutic benefit are the same as when rupture is not perceived to be a personal threat.

Open therapeutic ruptures often require a therapist's personal self-disclosure. Although in some cases not disclosing results in greater transparency-- as the therapist pays homage to the general principle of client process and needs having priority over the therapists, if the therapist believes that facilitating interaction and client process would be enhanced through self-disclosure, action might be taken. In such instances, therapists should listen to the client's response to the therapists disclosure bearing in mind that most important is facilitating client exploration of personal experiencing and its meanings. The interpersonal relationship is always a matter of two persons. Even though a client might experience something with me that is very similar to their experience with significant others, the client is not alone with the responsibility an optimal interaction. Furthermore, and in the spirit of humility, even though I relate to a client with the same attitudes that undergird my relationships with all people, I am

not expected to relate identically to my client as to others, and even if I do experience something similar with a client as with others, I can strive for more constructive interpersonal interaction.

In contrast, psychodynamic psychotherapy treats every interpersonal issue (and especially that of the therapeutic rupture) through the lens of transference and countertransference with a goal of client insight into interpersonal functioning. Psychodynamic therapists contend that clients arouse countertransference reactions within therapists through typical client-generated interactional patterns; only in exceptional cases does a countertransference reaction stem from a therapist's pathological pattern. Interpretation and explanation depend on accurate knowledge of who originated the interpersonal pattern. If it is the client, then all is well and the therapist interprets and explains. If it is the therapist, then the therapist must manage the transference outside the therapy, most typically in supervision. Thus, psychodynamic therapy presupposes that therapy is a place where the client is about to master pathological interpersonal patterns through the therapist's interpreting them in the context of the therapeutic relationship. In person-centered therapy, interpretation and explanation of client functioning occurs rarely, or not at all. Client's are not considered to arouse countertransference reactions through their pathological interpersonal patterns. Rather, person-centered therapists stay with the client's felt experience, trying to accept all of its nuances, and communicating their understanding of (or effort to understand) its felt meaning. They work to be transparent for the client, that is, to be open with their experience and perspective; and to be comprehensible for the client.

I previously cited two possibilities for experiencing a rupture by the therapist. The therapist is either integrated in spite of the client's challenge, or is threatened by the client's experiences. In both cases the helping factors for overcoming the rupture are the same. First is the therapist's transparent, congruent presence; and second is the endeavor to understand the client's felt meanings (with their historical and current importance for the client's being). These therapist ingredients empower the client's exploration because all parts of the client's self are recognized and approached equally (the fact that they concern the therapist does not prevent their exploration). The caveat is that in order to be empowering for the client, these ingredients must be felt by the client. A significant influence upon the client's capacity to perceive these elements is the therapists constancy of presentation. How can these elements be consistently generated and conveyed in an acceptable way to the client?

Whether the therapist is integrated when facing a rupture or not, the attitude of humility towards ones own imperfections and towards the realness and value of a client's perspective are useful in overcoming ruptures. Humility lowers a therapists defensiveness. It presumes a readiness to admit personal failure. Willingness, or readiness to admit failure makes defense unnecessary. Regardless of whether one feels vulnerable or well-integrated, the attitude of humility prepares therapists to admit that they could contribute to (and that they have most likely contributed to) the rupture that the client reveals. The attitude of humility may be especially important for therapists dealing with feelings of vulnerability, as feeling vulnerable increases the probability that one will experience difficulty admitting their share in a rupture. The strength to stay full of humility makes one more capable to face accusations or challenges without self-defense. It is not easy to congruently experience humility towards personal imperfections and towards a client's experiencing, nor to admit them openly.

However, work on the development of this attitude enhances discovery of possible clues for overcoming a rupture and thus growth. With the congruent attitude of humility, therapists are prepared to explore a challenge with openness rather than caution or defense. Moreover, congruent humility allows the client to not have to feel threatened by the therapists point of view. Humility communicates that ones own point of view does not denigrate the other. Even when a client does not recognize this conciliatory approach, the therapist can respect that, and still accept their own truth. This can create space for deeper understanding of the interaction. It is a spiral, where humility towards imperfection and towards the client's truth opens to deeper and more precise understanding of the interaction and thus to deeper understanding of both client and therapist interpersonal issues. Humility, therefore, becomes the key to unlocking the rupture. It can help overcome vicious cycles in a client's interpersonal experiences concerning specific aspects of (interpersonal) self. Humility facilitates corrective emotional experiences for clients because their experiences are encountered by the therapist in a constructive way.

The therapist's congruent experiencing of humility serves not only to resolve the sense of a rupture experienced by the client, but also increases tolerance of further failure experiences, and makes tolerance of failure experiences a natural part of therapeutic endeavor. As therapists grow more open to bearing client and self critique, they increase their capacity to remain in a helping stance rather than focusing on their vulnerabilities.

The presence of humility can be implicit (inside the therapist but not communicated directly) or explicit (expressed to the client) in the therapist's responses to the client. An experienced, sensitive, integrated and congruently humble therapist usually employs optimal ways to convey humility; even if not compelled by failure to communicate optimally, they are more at ease in correcting their mistakes.

An example of the presence of humility in response to an open rupture is as follows: The client accuses the therapist in private practice of being in the profession only to make money on others' unhappiness. The therapist's response might sound like this: "Something I have gone through with you makes you feel that I am really not competent" (this would be an implicit presence of humility), or one might say, "I am sorry that I probably have been somehow insensitive toward you" (it would be the explicit acknowledgment of one's fault and the explicit expression of humility towards the client). Such expressions of the therapist may help to carry forward the client's process of exploration and lead to a constructive therapeutic relationship.

Humility is a good precondition for using a rupture for therapeutic ends. Providing information and making empathic reflections are more facilitative when delivered from the humble position because the client is less likely to feel disempowered over lack of awareness of personal functioning. When humility permeates the therapist's communication, clients are more likely to perceive being valued and considered an equal collaborator rather than their being moralized to or mentored. Therapist willingness to admit imperfections enhances cooperation between therapist and client. Clients become less defensive and more willing to explore ruptures when they are not expected to be perfect, and when the therapist acknowledges responsibility for the rupture.

Agnew, Harper, Shapiro, and Barkham's (1994) research findings on relationship rupture in psychodynamic (exploratory) therapy of depression are not surprising in light of what has been proposed to this point. Agnew et al. studied important in-session relationship events chosen because of the client's evaluation of a positive shift in the relationship (a form of relationship inventory was used) in a successful single case. The researchers considered the resolution of interpersonal conflict between therapist and client to be crucial for change in the client's depression. Consistent with psychodynamic theory, they expected that resolving the conflict would follow certain steps (mostly exploratory and interpretative) leading to client insight regarding interpersonal functioning outside of therapy. They confirmed their expectations; but also discovered important elements of successful resolution to include 1) therapist acceptance and acknowledgment of responsibility for client dissatisfaction, and 2) presentation of the client's dissatisfaction as a normal part of the therapy and everyday life. "[T]he therapist's readiness to share responsibility for difficulties in relationships distinguishes her or him from the others with whom the client has experienced similar problematic experiences" (Agnew et al., 1994, p. 167). Likewise, consider Rhodes, Hill, Thompson, and Elliott's (1994) qualitative report on clients' retrospective recall of resolved and unresolved misunderstanding events in long-term psychotherapy. Rhodes et al. showed that the therapist's willingness to admit their part of an existing problem in the relationship was *the* important element for overcoming a problem. These findings, along with the literature presented by others (cf. Safran, 1993) point to the centrality of resolving client-therapist interpersonal problems for therapeutic success as a whole.

It may be clear from what has already been said that an important aspect of humility is a sense of respect offered to clients. Respect empowers clients in their motivation and fruitful activity in the therapy. Duncan and Moynihan (1994) pinpoint the importance of the therapist's respect for the client's informal theories which they have about the origins of their problems bringing them to therapy. Respect is present in the relationship when the therapist embodies the attitude of humility.

Conclusion

By emphasizing the importance of therapist humility towards personal imperfections and towards the client's experiencing and perception a new quality of the relation towards the client in therapy has been depicted. I do not consider therapists to be facilitative or useful when they consider themselves experts on what is best for the client-- on how the client should live or what is good for the client. The therapist's expertise is more in being human, which in part means being aware of ones shortcomings. Interpersonal skillfulness on the part of a therapist is not a problem, per se, but sometimes skillfulness doubles as defensiveness, and a mask for more genuine experiencing. Efforts to be the infallible expert who knows everything fail to offer the client the climate for potential growth. Real expertise lies closer to the core of the therapist's personality, the expression of which may be best expressed in the core attitudinal qualities. While it is very difficult to teach discovery of these qualities within oneself, they are the basis for therapist skillfulness. Starting with the basics means starting with me. Becoming a person-centered therapist involves growth in a facilitative way of being. It requires work on oneself and ones attitudes, and discovery of their presence in

interactions with others. The attitude of humility is for me quite necessary for overcoming relationship rupture for therapeutic change.

Humility may not be the only needed quality for improving the therapeutic endeavor, but the conscious and congruent acknowledgment of humility can be helpful. Congruence with humility is a never-ending process of growth which one can pursue in training, work, supervision and in everyday life. Person-centered attitudes are consonant with an attitude of humility. I do not propose perfection in this attitude, but rather, just the endeavor in its direction. Humility can be developed simultaneously with other attitudes in person-centered training, and can be addressed in supervision. To ask openly for feedback from others and to confront ones own intentions and ones impact on others in relationships can be a useful. To be open and risky, as Rogers often emphasized, can be painful but enriching.

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