

CRITERIA FOR MAKING EMPATHIC RESPONSES IN CLIENT-CENTERED THERAPY

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The criteria for communicating empathic understanding described in this paper are based on my work as a client-centered therapist. As my therapy evolved, I only gradually identified these criteria and recognized that they express the nondirective attitude that informs my practice. An early version of the paper was prepared for the First International Forum on the Person-Centered Approach in Mexico in 1982. An excerpt was published in the ADPCA newsletter, Renaissance, in 1984. In 1986 Carl Rogers published his article on "reflection of feelings" which gave support to my thesis that the client-centered therapist's intention in responding empathically is to verify understanding, not to manipulate the client's process nor to foster any therapist goal for the client. The fundamental nondirectiveness in client-centered work seems to be difficult for some students to understand or, perhaps, to believe. My hope that this paper will help to clarify the meaning of the nondirective attitude in empathic interaction process as well as clarify the criteria for overt empathic responding in client-centered therapy.

Client-centered therapy is a therapeutic approach theoretically based on the idea that all persons possess an inherent actualizing tendency. The actualizing concept involves an assumption that the motivation and capacities for personal growth, and the particular directions that evolve for such growth, arise from within the individual person (Rogers, 1951; 1980). Given this assumption of the client's inherent potential for growth and change, the therapist's function is to experience and express the therapeutic attitudes – congruence, unconditional positive regard and empathic understanding of the client's internal frame of reference – in relation to the client. Successful therapy also requires that the client perceive the therapist's empathic understanding and unconditional positive regard.

In the client-centered approach, the client is viewed as the best expert about the client (Bozarth, 1985; Bozarth & Brodley, 1986) and the "architect" of the process (Raskin, 1988). The therapist's nondirective attitude (Raskin, 1947) expresses trust in and respect for the client and a value to protect the client's autonomy and self-determination. It is an aspect of the therapist's personal philosophy of persons (Rogers, 1951, Chapter 2). In therapy, the nondirective attitude functions importantly to enhance the client's personal power and sense of self-value.

The client-centered therapist's overall goal is to facilitate a therapeutic climate in the client's experience. It does this through an interpersonal relationship wherein the therapist experiences particular psychological attitudes which may be perceived by the client. These attitudes, when perceived, promote therapeutic change and personal growth while they function to protect and enhance the client's autonomy and self-regulation. This general conception of the therapist's goal emphasizes the non-directive aspect of the client-centered philosophy.

As a consequence of holding this general notion of the therapist's goal and its emphasis on non-directiveness, when doing client-centered psychotherapy, I implicitly give myself the following instructions: (1) To experience and personally embody, as much as I can, the therapeutic attitudes of congruence, unconditional positive regard and empathic understanding in relation to the client. (2) To express acceptant empathic understanding to the client¹, often through explicit empathic responses, in order to check my inner understandings (Temaner, 1982; Rogers, 1986). And (3) to be willing to address the client's questions and requests as a person to a person without making assumptions (and without selectively responding according to such assumptions) about the possible benefits or harm to the client in getting honest answers. These rather simple sounding instructions result in a very complex, variable and sometimes difficult sequence of events and experiences for both therapist and client. Nevertheless, over many years I have continued to find these instructions useful, and the resulting experiences to be therapeutic – to be helpful to clients in fostering their growth and healing.

The question addressed by this paper arises out of one of Rogers' (1957) conditions for therapeutic change. He expressed this essential therapeutic condition in two different ways. In 1957 his theory stated:

The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved (p 96).

In a slightly different theoretical statement, Rogers (1959) wrote:

That the client perceives, at least to a minimal degree... the unconditional positive regard of the therapist for him, and the empathic understanding of the therapist (p 213).

On the basis of either statement, obviously, if the therapist is to communicate acceptant empathic understanding (not only experience these attitudes) then the therapist must behave in a manner that allows the client an opportunity to perceive these attitudes. It seems reasonable to assume that the therapist must at times make explicit empathic responses, along with nonverbal and expressive behaviors, that may communicate acceptance and empathy. The question logically following from this assumption is: When, or under what particular circumstances, or according to what criteria, should the therapist deliberately speak his or her understanding?

It may be helpful to clarify certain features of client-centered theory before articulating the specific criteria which answer the question of when, or under what circumstances, the therapist should deliberately speak his or her empathic understanding. To elucidate by contrast, I will first discuss a theoretical interpretation of the purpose of responses which is inconsistent with the basic theory.

Some client-centered theorists have developed the idea that explicit responses should evoke or stimulate the client's experiencing process (e.g., Rice, 1974). The unproved assumption behind this idea is that the fundamental cause of the change process is a particular experiencing process in the client (Leijssen, 1996). The problem with this idea is that it may produce therapist attitudes which undermine the essential therapeutic attitudes and essential character of the client-centered therapeutic relationship.

Specifically, the idea that therapists' responses must affect clients' experiencing process in a particular manner in order to promote therapeutic change requires the therapist to assume responsibility, at least at times, for the client having the "correct", or the truly therapeutic, experiencing process. This is likely to imply one of two things in respect to the therapist's behavior. One possibility is that the therapist must constantly be attempting to enhance, intensify or amplify the client's experiencing process. This is an unlikely meaning, given the general clinical observation that there are times when individuals appear to need to soften, or distance themselves from, the

intensity of their experience in order to maintain their integration. The alternative behavioral implication that the therapist should take responsibility for the client's experiencing process is that the therapist should be producing different effects (e.g., sometimes amplifying, sometimes softening the client's experience), for the client's benefit. Different experiences in the client are deemed the appropriate ones at different times or under different circumstances. This form of the inference, if put into practice, would require the therapist to engage in a diagnostic process and to engage in process directiveness (Greenberg, Rice & Elliot, 1993) in relation to the client. In either case, the therapist has taken on the task and responsibility of doing something to the client to produce an effect on the client. In both cases, the therapist is presuming to know what the client needs and, in the second case, presuming to know when he or she needs it. Both require the therapist to make ongoing decisions about what is to be done to affect the client repeatedly through the therapy session.

When a therapist moves into the realm of deciding what is best for the client in the context of the specific therapy relationship, or moves into the realm of decisions concerning what is best for the client at particular points in the therapy interaction, he or she is no longer functioning within the basic values of the client-centered position. This view of client-centered therapy has been eloquently argued on the basis of research, clinical experience and study of Rogers' writings and therapy behavior by Bozarth (1992). Bozarth states:

The essence of client-centered/person-centered therapy is the therapist's dedication to going with the client's direction, at the client's pace, and in the client's unique way of being. (p 13).

Certain values are thought to be, and seem to many of us who practice it to be, essential to the therapy's effectiveness. They are: (1) That the client is an autonomous person with growth and healing potentials within him or her self which the person is in the best position to utilize. (2) That the therapist is committed to respecting and protecting that self-direction and autonomy. (3) That the responsibilities of the client-centered therapist rest in the therapist maintaining and living out the fundamental values and attitudes that are believed to be the basis for constructive personality change and healing. Any form of paternalism² is inconsistent with client-centered therapy and undermines the distinctive client-centered relationship.

The actual general purpose of explicit responses in client-centered therapy is for the therapist to be a participant in an interaction between persons. Explicit responses, as well as the therapist's manner and tone – his or her presence, permit the client to perceive and understand the therapist. Within the interaction the therapist is trying to accurately and acceptantly empathically understand the client and the client has an opportunity to perceive the therapist's attitudes and the therapist's concrete accuracy of understandings. Explicit responses, along with a great variety of non-verbal behaviors that are also shaped by the therapist's therapeutic attitudes, are a major vehicle of communication to the client of the therapist's inner empathy and acceptance.

Setting the stage for presentation of the criteria for empathic responses in client-centered therapy also requires addressing the confusion that exists concerning the role of technique in client-centered therapy (see Bozarth & Brodley, 1986; Brodley & Brody, 1996). Some teachers and practitioners have misunderstood Rogers' theory of therapy and mistakenly identify client-centered therapy with the use of the technique of "making reflections" (Rogers, 1986) or the technique of "active listening" (Gordon, 1970). In both of these techniques, the therapist makes a kind of restatement of the client's expression. Techniques of restatement are often employed subsequent to each unit of completed communication (roughly each spoken paragraph, or coherent idea or feeling) by the client. These techniques may, in fact, be helpful to clients and may produce a therapeutic change process, but they are not appreciative of Rogers' conception of therapeutic

empathic understanding. Rogers' theory emphatically emphasizes the therapist's attitudes and feelings, not techniques, in the therapy relationship (Rogers, 1957).

Rogers' theory also asserts that the client must to some extent perceive and experience the therapist's attitudes. Such reception requires the therapist to have transmitted attitudinal information to the client. Spoken communication is highly likely to be at least part of the vehicle of transmission. It is, therefore, reasonable to refer to a means to an end technique element in doing client-centered therapy or in teaching it. It may, for example, be developmentally useful to students of therapy to practice reflecting the utterances of a practice client, or practice "active listening" as a technique to help students become comfortable with responsiveness and interaction in the therapeutic relation, or to become confident in their ability to represent the communications of another person from that person's point of view. But practice responding for these and other didactic purposes should not be confused by the student or teacher with client-centered therapeutic responding in which the therapist's attitudes determine his or her behavior (Brodley, 1995; 1997).

In Rogers' theory of therapy the attitudes and feelings of the therapist which become successfully communicated to the client are among the causes of client therapeutic change. Successful communication may have been achieved, however, through some different means than by making empathic understanding responses (Bozarth, 1984).

There is no dogma of technique in Rogers' theory. There is, actually, no technique in the real therapeutic process, if technique means deliberately employing means towards desired ends (Brodley, 1995; Brodley & Brody, 1996). It does not matter, from the perspective of efficacy, how the therapist gets the therapeutic attitudes across to the client. As long as the particular client experiences acceptant empathic understanding (without experiencing contradictory experiences, or at least a minimum of other experiences which contradict those attitudes) from a therapist who comes across as authentic. Empathic understanding responses are only given emphasis in explaining the therapy because in most situations, with most clients, they are a form of overt responsiveness that can express the therapeutic attitudes and that have a likelihood of being perceived as acceptant empathic understandings.

Practices of speaking reflections, speaking empathic understanding responses, doing active listening, or doing any practices that are done as technique produce a different quality of relationship and interaction process, and one that is less therapeutic, than the relationship Rogers had in mind when expressing his theory.

Nevertheless, if a therapist does not make specific decisions about what is best for a client while interacting and responding, and does not engage in a routine or ritual application of technique, the therapist still needs a criterion, or criteria, for explicit expression of empathic experience of the client. The basis for explicit or overt expression should be (1) consistent with the growth premise of the theory, (2) consistent with the client-centered conception of causality as resting in a combination of the attitudes of the therapist and the basic nature of the person, and (3) consistent with the value placed on promoting and protecting the client's autonomy, self-regulation and self-determination. In addition, the basis for overt responses should be (4) consistent with what Rogers' considered the primary therapeutic attitude (Baldwin, 1986) – the therapist's congruence. Congruence refers, specifically, to the therapist's wholeness and integration. When he or she is congruent, the therapist's responses are authentic, and thus will probably feel authentic to the client.

The Empathic Interaction

Explicit empathic responses occur in the context of an empathic understanding response process (Temaner, 1977) within the client-centered relationship. The typical events of empathic interaction are as follows:

(1) The client talks to the therapist and expresses or describes some of his or her feelings, concerns, thoughts or life events. The client articulates something from personal experience and from his or her own viewpoint that he wishes to communicate at that time to the therapist (and may wish, also to say out loud to hear for himself).

(2) While the client is expressing his or her experience the therapist is giving a full and undistracted attention to the client. The therapist is attempting to receive, to absorb and grasp the meanings and feelings the client is saying or trying to say from his or her own point of view, taking it in until the therapist has it in his own experiencing process such that he feels he understands to some extent (or does not have that feeling of understanding and recognizes the fact).

(3) Next, the therapist may or may not make an explicit response that communicates his or her inner understanding (or acknowledges lack of understanding) to the client. If the therapist does not make an explicit verbal-oral response, he may nod, make a vocal gesture such as "Uhm-hm", or simply remain attentive and silent in a way that implies understanding to the client.

(4) Finally, in this "empathic cycle" (Barrett-Lennard, 1981), in response to the presence, the attention, or the explicit responses of the therapist, the client may have the feeling of being understood and accepted. These experiences tend to stimulate the client to further self-reflection and expression³.

Over the years I have practiced, trying to develop my capability as a therapist from a client-centered theoretical perspective, I gradually realized I was spontaneously using criteria for making empathic responses which met theoretical conditions. These criteria are based on the wants or feelings of the therapist (given the general therapeutic intention and commitment to the therapeutic attitudes), or based on the request for response by the client. I distinguish five different criteria for making empathic responses on these particular bases. Each of the five are compatible with the nondirective attitude intrinsic to the theory. I shall describe these criteria in terms of circumstances that may occur in the first and second steps of the empathic interaction cycle (when the client is self expressing and the therapist is attending and absorbing). Any one of these criteria is a sufficient reason for making an explicit response.

The Criteria For Making Empathic Responses

1. *When the therapist feels some understanding but also experiences some uncertainty because of an ambiguity or imprecision or confusion perceived to be located in the client's communication.*

In this case the client's statements have been experienced as somewhat unclear by the therapist, but clear enough or coherent enough for the therapist to attempt an explicit response. (If the client's statements have been experienced as so unclear that the therapist does not feel any understanding, the therapist would usually ask the client for a restatement or new expression of what the client was trying to communicate.) If the client has not been fully understood because of coming across as unclear to the therapist, the client may or may not realize this when the therapist makes the response to check inner understanding. The therapist's aim is not to point out the client's imprecision. The empathic response, rather, is aimed to elicit the client's validation, correction or elaboration concerning what he or she is trying to communicate.

2. *When the therapist feels uncertain about his or her understanding of the client's communication.*

The therapist perceives the feeling of uncertainty to be located in the therapist's reception or absorption of the client's communication. The uncertainty about understanding coexists with the feeling that the client's communication was clear and coherent enough to be understood. The therapist feels unsure of his or her own grasp of the client's meanings or feelings.

3. *When the therapist feels an impulse or desire⁴ to express and communicate his or her self while immersed in the attempt to empathically understand.*

This impulse or desire to express oneself which is resolved through expression of understandings probably originates in the interpersonal and interactional nature of the psychotherapeutic relation. Inherent in an interpersonal relation is an expectation of an exchange – a back and forth characteristic of the interaction. The deeply empathically engaged therapist, however, seldom will experience any specific content from his or her own frame of reference that could serve as a vehicle for self expression. Thus when the interaction involves almost exclusive focus and attention on the client member of the dyad, the therapist may feel the desire to be responsive and expressive through the vehicle of tentative empathic understandings.

4. *When the therapist feels the need to establish the client's communication in experience or memory.*

The therapist may feel a need to make an explicit empathic response, possibly even a relatively literal one, in order to help him or herself get the client's meanings incorporated into his own experience and memory. This form of empathic response sometimes may be prefaced with a brief explanation such as "I just need to be sure I have that clear in my own mind. What you were just saying is"

5. *When the client asks the therapist if the therapist has been able to follow or understand, or asks the therapist whether the client has been clear in communication.*

In some instances the client may not ask explicitly, but conveys by a behavioral cue (e.g., the client looks searchingly at the therapist along with an incomplete expression of his or her idea), or an indirect expression (e.g., says "I don't know if I'm making sense") indicating he or she is wondering if the therapist understands. In these somewhat ambiguous instances the therapist may directly make an empathic response (or may first ask the client if he or she is concerned right then about being understood).

The above criteria for making explicit empathic responses, except for the fifth which is directly responsive to the client's wishes, have to do with the feelings of the therapist. None of the five are based on any therapist speculation, judgment or assessment of the client's needs for a response. They all express the therapist's intention to experience accurate, acceptant, empathic understanding and the therapist's respect for the client as the determinant of what is or is not accurate. The criteria are nondirective and nonmanipulative in relation to the client. The therapist's specific and concrete intention in making empathic responses is simply to participate in empathic understanding of the client as a process of absorbing tentative understandings that become validated or corrected by the client.

The criteria are meant to be implicit guides to promote the achievement of the therapeutic attitudes in relationship with the client. I do not mean that the therapist in the midst of therapy should mentally run down the list of criteria, then make sure one of them is met, identify it, and then and only then make an explicit response to the client.

A main purpose in clarifying these criteria is to emphasize that the client-centered therapist relates to his client in a spontaneous and conversational manner. The therapist has a specific purpose, to be an effective therapist, but the manner of achieving effective therapy emerges from the sincerity of therapeutic attitudes, not through rational matching of means to ends. The client-centered manner does not involve making or acting upon speculations or inferences concerning the specific client. Nor does it involve speculations or inferences concerning the client's specific needs, nor judgments about how to foster the client's well-being in specific instances. Obviously, the entire theory involves inferential general judgments about what is therapeutic and what is not. Having a general position – a theory – is quite different from making moment to moment decisions concerning clients.

Adopting the criteria I've described for making responses, before the concrete occasion of doing therapy with clients, will likely influence the therapist through an implicit subjective process when he or she is doing therapy. Knowing the criteria should not lead to a conscious decision process added to the therapist's task while doing therapy. Often, when listening to recordings of empathic interactions, the therapist can identify which one of the criteria was operative when making specific responses. But even when so listening, it is not always possible to recognize or remember the operative criterion – and that is of no matter. The important thing is that the therapist has been genuinely trying to understand, not trying to exercise some conceived power to produce therapeutic effects on or in the client.

The criteria described are those which undeliberately influence the specific and concrete intention of the therapist in the empathic interaction. It should be understood – very emphatically – the client-centered therapist is, in principle and in the heart, not intending to produce effects on or in the client when doing therapy. The therapist is simply, but profoundly, being him or herself in a person to person interaction. In this way the therapist is giving him or herself to empathic reception and to following of the client and wanting, from time to time, to communicate about his or her empathic experience of the client to the client⁵.

The mechanisms of change in client-centered therapy are thought generally to be in the transmission of the therapeutic attitudes of the therapist from the therapist to the client. Consequently, the client becomes more integrated, more self-accepting and more empathically understanding towards him or herself (Rogers, 1984). I believe this view points to the truth about therapeutic change and that, additionally, more specific processes can be described for individual clients within this general process framework. I do not believe there is only one therapeutic change process for all clients in the context of client-centered therapy. Rather, that the integrity of the relationship – one containing, consistently and without contradiction, the living out of the therapeutic attitudes by the therapist – allows whatever specific change processes are at work within particular clients. It is obvious to me, based on my work with many people, that therapeutic effects are produced when the therapist is free of specific intentions to produce effects on or in the client. Many different therapeutic processes and effects⁶ do occur in the client-centered therapist's clients as the therapist works purely from the theory and empathically with clients. These effects seem to contribute in sometimes unexpected ways to accomplishing the general purpose and goal in the situation – the healing and growth of the client.

Indeed, there are many immediate and prevailing effects and impacts on clients as the consequence of the empathic relationship and interaction. But – while functioning in the spirit of the client-centered philosophy and embodying its values – the therapist is not intending to produce these or other beneficial effects. The therapist's specific and concrete intention is to be as present as possible in the relationship and to acceptantly and empathically experience and understand the client.

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NOTES

¹A major category of empathic responses are often termed “empathic understanding responses” (EURs) . EURs refer to a broad category of responses all of which are an attempt to accurately articulate the experience the client has expressed or has been striving to express. EURs range from very literal restatements or summaries of what the client has expressed, to more fragmental responses, to forms of response which involve more inference or guessing about what the client has been expressing. But in all instances of EURs, they represent the therapist’s attempt to articulate the client’s point of view and are an attempt at an empathic following of the client. They are not based on an attempt to interpret the client or get ahead of the client’s awareness of his or her experiences.

²Paternalism is generally defined as doing something for, or to (or with-holding from), another person, with the intention of doing the person some good, without the person’s consent.

³ In the client-centered therapeutic situation, wherein the therapist experiences and embodies the therapeutic attitudinal conditions and when the “empathic cycle” occurs and reoccurs, a distinctive therapeutic process is taking place which I have termed “the empathic understanding response process” (Temaner, 1977).

⁴ This impulse or felt desire is not anxiety and should be consciously discriminated from anxiety feelings. A feeling of anxiety to make a response to the client may be stimulated in therapists (especially new therapists) when they or the client have been silent for awhile. The feeling of anxiety-to-respond is best taken as a cue to regain congruence, to relax, give oneself a chance to reflect on the impulse and dispell the anxiety.

⁵ The assumptions behind this extreme non-directive, non-manipulative position are that (1) the autonomy and self-regulation of the client need protection in a therapeutic relationship even when the therapeutic conditions which are believed to cause constructive change are being provided. (2) the growth potential of the person is assumed to be the effective force that moves the individual towards growth and health. (3) The therapist provides an optimal psychological environment conducive to the client’s potential for constructive change and health but the therapist also needs to be highly sensitive to the potency of his personality, status and role in the relationship. Note that all these are assumptions prior to the specific therapeutic relation, and apply in relation to all clients.

⁶ I have observed a number of different effects of empathic interaction which seem to be aspects of change processes in particular clients. Some examples: The client becomes reassured that he is understandable. The client feels himself becoming less confused or more coherent to himself. The client feels more understanding of his motivations, values and feelings. The client feels cared about and valued, less alone, less alienated, less different from other people, or less strange. The client feels more understanding of others, their motivations and feelings. The client feels he or she is being more realistic and open to the way things are. The client feels more aware of subtle processes of feeling and meanings within himself. Clients have reported that they feel these and many other effects and processes to have been stimulated by interaction with an acceptant and empathic therapist.

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