REASONS FOR RESPONSES EXPRESSING THE THERAPIST'S FRAME OF REFERENCE IN CLIENT-CENTERED THERAPY

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ABSTRACT. This paper proposes reasons client-centered therapists occasionally may make responses from their own frame of reference. Thirteen reasons are described. The risks involved in therapist-frame responses to the client's sense of safety, freedom, and perception of the therapeutic attitudes, are discussed and emphasized.

The nondirective attitude is fundamental in client-centered therapy (Brodley, 1997a). This principle is integrated into the client-centered therapist’s intention to experience congruence, unconditional positive regard and empathic understanding in relation to clients (Rogers, 1957; Brodley, 1996). The totality of these attitudes usually results in responses that represent or express the client’s frame of reference. These responses, termed “empathic understanding responses,” are expressed for the purpose of checking with the client concerning the accuracy of the therapist’s understandings (Rogers, 1986; Brodley, 1998a). Most other responses express the therapist’s frame of reference, even when their content is about the client.

Tomlinson and Whitney (1970) have discussed the reasons client-centered therapists usually respond to clients with empathic responses. Little has been written, however, concerning the reasons client-centered therapists occasionally do respond to their clients from their own frame of reference (Rogers, 1957; 1961; Baldwin, 1987; Brodley, 1998b; 1998c). This paper will discuss reasons client-centered therapists may make responses that represent their own frame. The reasons will be embedded in caution, warnings and some guidelines for therapists about this practice. My aim is to help students of client-centered therapy develop a differentiated awareness concerning the possibilities and the limitations of therapist-frame responses.

I think it is inevitable that client-centered therapists will make responses representing their own frame of reference from time to time – sometimes for very good reasons.


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Nevertheless, I do not wish to encourage this practice. Clients and the therapy relationship may suffer harmful effects when the therapist temporarily abandons empathic understanding. My aim is to encourage therapists' sense of freedom by clarifying reasons for therapist-frame responses, while I also advocate a conservative, self-aware and disciplined approach.

It is a fact that client-centered therapists sometimes make responses from their own frame of reference to their clients. In a sample of 31 of Carl Rogers’ recorded sessions (Brodley, 1994), a mean of 10% of his responses (with a range of 0 to 14%) were therapist-frame remarks that had not been elicited by questions from his clients. In a 1998 sample of 14 other client/person-centered therapists, the self-estimated mean of responses from the therapist’s frame of reference was 8% (with a range of means of 3% to 25%).

The written theory has not offered much rationale for therapist-frame responses to self-exploring clients. For the sake of responsible practice it is important to have theory for making these kinds of responses. It is also important to realize the possible risks to clients as the result of even temporary loss of the acceptant, empathic relation to the client, which may occur when the therapist self-represents.

Theoretical Context

Recall that client-centered therapy is a therapy of values and attitudes (Rogers, 1951; 1957; 1959; 1980; Patterson, 1989; 1990; Bozarth, 1992). It is not a diagnostic type of therapy, which would require the therapist to conceptualize or diagnose the client’s problems, conceptualize goals for the client and employ techniques to meet those goals. Client-centered, in contrast to most if not all other therapies, is an expressive kind of therapy (Brodley, 1997). The therapist’s behavior flows from attitudes of strategies. The behavior expresses attitudes and values. In accord with this expressive character of the therapy, the type of responses employed by the therapist and the therapist’s manner with the client are primarily determined by generic, theoretically grounded, intentions. These generic intentions-- to acceptantly, accurately, empathically understand -- apply to all clients.

Client-centered responses are determined, as well, by characteristics of the client as they are experienced uniquely in the relationship. Thus, the content of responses (both information and affective features), the therapist’s frequency of response, rate of response, complexity of the structure of responses, vocabulary level, etc., are adjusted to the particular client. These adjustments are made on the grounds that (a) the therapist is attempting to understand the client and (b) when the therapist responds, the client must understand the therapist. Attunement to the client’s language and his cognitive-affective complexity in the relationship also protects the client’s sense of safety and comfort in the relationship. Adjustments to the client, however, are not made on the basis of classificatory considerations about the client such as diagnoses.

The Role of the Non-Directive Attitude

A nondirective attitude guides and constrains the client-centered therapist (Brodley, 1997). It is intrinsic to the totality of congruence, unconditional positive regard and empathic understanding. This attitude shapes and molds essentially all of the therapist’s behavior and
responses with clients. The theoretical basis for the nondirective attitude rests in implications of the actualizing tendency construct.

The actualizing tendency— the client-centered basic assumption, or axiom-- implies a fundamental respect for and trust in persons’ capacities for socially constructive self-determination under favorable circumstances (Bozarth & Brodley, 1991; Brodley, 1998d; 1999 in press). The actualization tendency is believed to promote the development, social capabilities and healing of persons most powerfully when they are exposed to and experience empathic understanding and especially when they experience acceptance (Bozarth, 1996; 1998). The nondirective attitude is cultivated and maintained by therapists because of the primacy of their commitment to, respect for, and trust in the client as they provide the therapeutic conditions. The idea of the actualizing tendency concept tends to motivate the therapist to place a high value on protecting the client’s sense of self and protecting the client’s autonomy and self-determination. The therapist respects the client as the primary director— the “architect” (Raskin, 1984)—of the therapy process. The principle of trusting the client as the best expert about himself should over-ride the therapist’s inclination to communicate her wisdom in all but very rare situations. Trust in the client includes willingness to accommodate to the client’s wishes within the therapist’s personal and ethical limitations. These accommodations will be discussed later in the paper. There is a caveat concerning them however, which is relevant to understanding the nondirective attitude.

Concretely, in specific instances, the clients’ wishes or inclinations may or may not promote the best direction of the moment for him. Nevertheless, the client is treated as the best expert about himself. Even if that assumption may be revealed to not be valid in the particular case, the client-centered approach still emphasizes the therapeutic wisdom and potency of the client. An important factor in this issue of following the client’s direction is that the approach is conceptualized in terms of process. The client tries something, then observes and feels the consequences of it. He then tries something else, or makes corrections. If the client’s original direction is unproductive or unsatisfying, the therapist’s acceptance, nondirectiveness, and empathy promotes the client’s discovery of this outcome and promote self-corrective processes.

Therapists who maintain an acceptant and empathic attitude in relation to their clients and who seldom comment, interpret or otherwise intervene from their own frame (unless that is requested by the client) tend to promote a safe and consistent climate. This climate stimulates the client’s trust in the therapist and in himself. Consistent empathic following promotes clients’ clear discrimination of the occasions when the therapist is representing her own frame of reference. Clear discrimination permits the client to evaluate his own responses in relation to the therapist. This facilitates clients’ realistic assignment of responsibility to their own psychological characteristics.

Acceptant Empathic Understanding

The empathic understanding attitude together with acceptance and congruence are the core therapist attitudinal conditions in client-centered work. Empathic understanding in practice involves a subjective process of close following of the client’s explications, disclosures, and immediate feelings with the intention to understand from the client’s perspective. This subjective, close following is imbued with acceptance and responsiveness towards the client as well as the effort to understand and be present.4
The most frequent pattern of interaction in client-centered work is the "empathic interaction response process" (Temaner, 1977). This interaction process expresses the therapist's acceptant empathic attitude very well with most self-expressing, narrating clients. It fosters a self-directed process of introspection and personal exploration in clients. The therapist's role of communicating her empathic attitude in the process is embodied in acceptant, empathic understanding responses and other following responses.

The empathic understanding form of response is prevalent in client-centered therapy work. It is probably an inevitable form of response given the theory. Nevertheless, it is not a requirement. Empathic responses express the therapeutic attitudes and communicate effectively with most self-exploring clients. But in principle it is not a necessary form of communication in the therapy. Empathic responses are prevalent therapist utterances in client-centered work because they express the empathic understanding attitude, concomitantly express unconditional positive regard, and are nondirective in their intent. Clients can easily understand them, and they can be an authentic expression of the therapist's attitudes towards clients. They are also responsive to the client's intention and drive to disclose, express and explicate self.

Other forms of response, however, may express the empathic attitude (Rogers, 1957). There are examples in Rogers' therapy transcripts of responses that are not empathic understanding responses, but which nevertheless have empathic intent. In one of his interviews, the client, Jim, has been silent for over two minutes. Then Jim yawns and Rogers (1967) makes an empathic guess, saying, "Sounds discouraged or tired" (p. 404). A little later in the same interview, after a silence of 48 seconds, Rogers makes another empathic guess followed by an empathic question for clarification. Rogers says, "Just kind of feel sunk way down deep in these lousy, lousy feelings, Jim?-- Is that something like it?" (p. 404).

Another example from Rogers own interviews occurs when his client (Rogers, 1986c) begins to manifest abrupt involuntary jerking motions of her body. Rogers asks a leading question - one that has empathic intent. Rogers says, "Can you say what those jerks mean to you?" (p. 7).

Another example of an empathic communication that is not an empathic understanding response occurs in Rogers' interview with Phillipe (1981). Phillipe remarks concerning his own courage, "And it felt good at the moment, and I feel proud of that." Rogers' response is an observational comment. Rogers says, "I can see it in your face." Although representing the therapist's frame, it has empathic intent.

Rogers (1986a) discussed his own theoretically based nondirective reason for uttering empathic responses. He explained that empathic responses are aimed to check his accuracy in understanding the client. The client is the expert about the therapist's accuracy in understanding. Thus, the therapist needs to let the client know his inner understanding in order to get feedback from the client. I have proposed five nondirective criteria for making empathic responses (See Temaner, 1982; or Brodley, 1998). These criteria are deduced from the basic theory of therapy (Rogers, 1956; 1957; 1959). Reasons the client-centered therapist might respond from her own frame of reference, however, do not stem as directly from the theory.
When the therapist’s standard behavior involves a mixture of empathic understanding and interpretive, didactic, guiding or self-disclosing responses, there are a multitude of counter-therapeutic meanings and effects this behavior may have for clients. Clients often do not consciously identify the problems affecting them that arise from frequent instances of therapist-frame responses. The problematic impacts are submerged in the client’s occupation with understanding the therapist’s intentions or meanings or are submerged in self-protective strategies. Other confused or self-protective counter-therapeutic effects may involve clients’ self-denial or their surrender to the therapist’s power.

Basic client-centered therapy theory—provision of unconditional positive regard and empathic understanding by a congruent therapist—combined with the therapist’s salient nondirective attitude, reveals no obvious reasons for therapist-frame communications. Rogers’ (1957) discussion of his theory, however, suggests some reasons for such responses.

Guidance From Rogers Concerning Therapist-Frame Responses

Recordings and transcripts of Rogers’ therapy work reveal that he expressed only a small percentage of responses (such as comments, agreements, leading questions, explanations, interpretations or self-disclosures) from his own frame of reference (Brody, 1990; Brodley, 1994; Merry, 1996). In some interviews there are no such responses at all. The transcripts and tapes of therapy sessions in themselves, of course, do not reveal what criteria or reasons are at work in Rogers’ mind when he does make therapist-frame responses.

In his discussion of congruence in therapy, Rogers (1957) gives a lead to two reasons the therapist might respond to a client from the therapist’s frame. He describes congruence as a state of “integration and wholeness” (p. 93). An integrated state is defined in terms of an accurate relation between experience and symbolization, or an accurate relation between experience and the self. He writes:

[Congruence] means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It would take us too far afield to consider the puzzling matter as to the degree to which the therapist overtly communicates this reality [referring to counter-therapeutic feelings] in himself. Certainly the aim is not for the therapist to express or talk out his own feelings, but primarily that he should not be deceiving the client as to himself. At times he may need to talk out some of his own feelings (either to the client, or to a colleague or supervisor) if they are standing in the way of the two following conditions [referring to unconditional positive regard and empathic understanding] (p. 224).

These reasons pertain when the therapist is not being empathic or the therapist is not experiencing acceptance, and this situation persists. The reasons for responding from the therapist’s frame, and disclosing the contradictory experiences, are (a) in order that the therapist will not be deceiving the client and/or (b) to create a process, by talking out her feelings, that changes the therapist’s non-acceptance or non-empathy to acceptance and empathy.
Rogers (1957) also referred to a third reason the therapist might make responses from her own frame:

...the techniques of the various therapies are relatively unimportant except to the extent that they serve as channels for fulfilling one of the conditions...the theory I have presented would see no essential value to therapy of such techniques as interpretation of personality dynamics, free association, analysis of dreams, analysis of the transference...these techniques, however, may be given in a way, which communicates the essential conditions, which have been formulated. (pp. 233-234).

Rogers' point is that certain responses from the therapist's frame of reference, "given in a way" that communicates the conditions, may contribute to the client's experience of the therapist's congruence, unconditional positive regard and empathic understanding. Rogers does not discuss the way this might be done. Most techniques from other therapies express purposes that are inconsistent with client-centered attitudes. He does not give examples to help us. Difficult as it may be in practice, Rogers' point does suggest a potential rationale for responses from the therapist-frame. They may contribute to the client's perceptions of the therapist as authentically providing acceptant empathy.

Rogers had stated the therapist might tell his client about persistent feelings that contradict the therapeutic attitudes. He reiterated this criterion for therapist-frame responses in his introduction to his interview with Gloria (Rogers, 1966). Late in his life, Rogers revealed he had made some change in this earlier conservative position on self-disclosure. Rogers (Baldwin, 1987) referred to an example from his work with a schizophrenic client in which he spoke directly to the client of his caring feelings. His example introduced a statement that contributes to the present discussion.

...I am inclined to think that in my writing perhaps I have stressed too much the three basic conditions (congruence, unconditional positive regard and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is very clearly, obviously present. (p. 45)

Rogers added:

When I am with a client, I like to be aware of my feelings, and if there are feelings which run contrary to the conditions of therapy and occur persistently, then I am sure I want to express them. (p. 45)

Rogers was not conducting therapy on a regular basis at the time he made these statements during his interview with Baldwin. His public demonstrations, during the final ten years or so of his life, that were intended to illustrate his personal version of client-centered therapy, included very few self-disclosures (Brody, 1992; Bradburn, 1996). It seems reasonable to infer from his therapy behavior that Rogers was not advocating a manner of conducting individual client-centered therapy in which presence is defined in terms of self-disclosures. Nor was he advocating self-disclosure as a frequent form of response although presence was given importance. His statement above does not provide a rationale for the self-
disclosure type of response from the therapist’s frame. It does suggest an effect of self-disclosure. Such responses may communicate the therapist’s presence to the client.

**Kinds of Responses from the Therapist’s Frame of Reference**

There are many possible kinds of therapist-frame responses. They include responses about the therapy, comments about something else other than the client, or comments about the client. They may be suggestions, explanations, interpretations, instructions, descriptions, information, emotional exclamations, leading questions or self-disclosures. The reasons the client-centered therapist may have for expressing any of these kinds of response should conform to the general theory as much as possible and certainly should not contradict the basic principles of the approach. In other words, the therapist trusts the client’s drive to realize his nature as best he can and trusts that the client has capacities that are adequate for realization and healing. Consequently, a very unlikely reason for a response from the therapist’s frame is that the therapist believes it would be for the client’s good. Client-centered therapists do not assume authority over their clients’ experiences or well-being. They deliberately, and generally, avoid behavior that might be damaging to clients’ self-regard. At the same time, they eschew patronizing behavior that assumes what is best for their client.

**Normal Inconsistency in Practice**

Responses from the therapist-frame risk directive impact on the client regardless of the therapist’s nondirective intentions. Sometimes, as well, the therapist does experience and express a momentary directive intent. This may be surprising, given the strong nondirective principle in the theory. The efficacy of Rogers’ theory (1957; 1959), however, does not depend upon an absolute therapist consistency in any of the therapist's attitudes. Rogers (1957) wrote:

> Only condition 1 (psychological contact between therapist and client) is dichotomous (it either is present or is not), and the remaining five occur in varying degree, each on its continuum....If all six conditions are present, then the greater degree to which conditions 2 to 6 exist, the more marked will be the constructive personality change in the client. (p. 229).

Rogers’ theory does not involve the expectation that it is possible to maintain the therapeutic attitudes with absolute consistency. The therapist wants and tries to constantly experience the attitudes in relation to clients. The more consistently they are experienced (and the more they are perceived by the client), the more effective the therapy. The distinctly client-centered therapeutic relationship, however, does not suddenly disappear if the therapist briefly loses congruence, acceptance or the empathic attitude.

The client’s sense of safety and freedom may be unaffected, or only momentarily affected, by minor inconsistencies in the therapist’s attitudes. Client-centered therapy’s efficacy depends upon the client’s perception of the therapeutic attitudes. A brief lapse in the therapist’s inner experience of the therapeutic attitudes may not be perceived by a client, especially not by clients who are concentrating intently on their own thoughts and feelings.
Paradoxically, over-consistency in the manner the attitudes are implemented may be detrimental to the relationship. It should be recognized that consistency and over-consistency are perceptions, not objective facts. Absolutely consistent empathic responding that closely follows the client may not result in the perception of over-consistency. It is likely to be perceived, however, if the therapist is reluctant to address questions or engage in minimal social interactions. The perception also may result from empathic responses that are cognitively accurate but emotionally inadequate. It may be the consequence of a lack in the therapist’s spontaneity and therapeutic presence. Consistent but shallow empathic understandings also may stimulate the client’s perception of over-consistency. He may perceive the therapist as expressing a false self. Over-consistency may be perceived as a disguise that covers non-acceptance.

In rapport with Rogers’ late-in-life writings and talks (1980; 1986b; Baldwin, 1987), Raskin (1984) has asserted that the client-centered therapist may respond occasionally from her own frame of reference in various ways. Raskin’s view is that doing so is an expression of a desirable therapist freedom-- that it is valid in client-centered work as long as such communications are not systematic.

Empathic understanding is literally contradicted when the therapist represents her frame of reference. Limited literal contradiction of empathic understanding, however, may not undermine the therapeutic relationship especially if the therapist-frame remarks have empathic content. An occasional moment of self-representation need not be experienced as a contradiction to the therapist’s basic subjective context-- maintaining the therapeutic attitudes.

It should be obvious that there is no contradiction to congruence when the therapist communicates from her own frame of reference, as long as the therapist remains integrated and whole herself. Congruence is not inextricably tied to acceptance or empathic understanding although in effective therapy they function together as a totality. Thus the therapist may remain congruent when experiencing the loss of acceptance or empathy.

The therapist’s experience of acceptance of the client also need not waver when she expresses therapist-frame communications. There are, however, many more opportunities for the client to perceive or misinterpret the therapist’s remarks as implying non-acceptance when the therapist communicates from her own frame. Whatever the momentary deviation from acceptant empathy, clients are most likely to continue to continuously perceive the therapeutic attitudes if the therapist immediately resumes attention to the client’s phenomenology.

Another normal contradiction, infrequent as it is in client-centered work, occurs when the therapist’s remarks have a rare momentary directive intention. The therapist thinks the client needs, for his therapeutic good, to hear something from the therapist. Or the therapist wants to influence the client toward some particular idea, action or value. Or the therapist wants to change the manner in which the client is engaged in the relationship. An occasional, albeit rare, moment of directive intention need not contradict the nondirective attitude as a constant in the relationship if the directivity is not systematic and not frequent. That is, if the directive intent is only momentary, or if the therapist experiences her investment in her directive intention as tentative or if it is only a brief impulsive reaction, or if there are special circumstances. For example, the therapist urges her client to make an appointment with a neurologist to medically evaluate sudden symptoms of severe headache.
Human motivations, states and attitudes are inherently complex and full of contradictory feelings and experiences. Although therapeutic work is disciplined, it must also be spontaneous. Thus inherent experiential complexity may occasionally result in impulsive reactions within the disciplined context. Momentary fluctuations in the three therapeutic and the nondirective attitudes need not contradict the therapist’s commitment to the attitudes. Nor do fluctuations necessarily undermine the client’s experience of them. Therapeutic work is a process. In assessing meaningful therapeutic consistency, we look at sequences of interaction, not just single acts. On the other hand, some clients may feel misunderstood, unaccepted or betrayed by even momentary directive communications.

**Counter-Therapeutic Consequences of Therapist-Frame Responses**

There are many possible counter-therapeutic consequences of therapist-frame statements to clients. Time is taken from clients’ use of the limited therapy time. Clients may become distracted from their own focus and introspective process. Clients may feel they are being evaluated or judged. They may lose their sense of self-determination and empowerment in the therapy process. In theoretical terms, a client’s *locus of evaluation* (Rogers; 1959) may be influenced away from within himself towards the therapist. Clients may become confused or defensive about the therapist’s intentions, perceiving the therapist as having his own agenda for them. In addition, comments from the therapist’s frame are inherently more difficult for clients to understand than empathic understanding responses.

Many forms of *process disruption* (Diss, 1996) are a result of therapist-frame communications. These may occur either when the therapist does not have directive intentions or when her responses express directive attitudes. Even when they are infrequent and in the context of highly consistent empathic understanding they may be disturbing to some clients. The general impact of any of these effects is to jeopardize clients’ self-determination and their sense of safety and freedom in the relationship. These negative effects can happen along with appealing client reactions, such as expressions of appreciation for the therapist’s helpful intentions or thanks for the help of specific interjections.

The fact that a client expresses liking for a therapist’s response does not guarantee it was harmless to the client. A broader perspective about what may be damaging to clients, in general, should qualify the therapist’s personal reception to clients’ praise. Such perspective may also protect the therapist from false ideas about what is a good thing to do with clients. Therapists need to distinguish (a) their respect for and accommodation to the particular client’s wants or directions from (b) general therapeutic instructions.

After sessions, therapists are wise to reflect upon their work during the session. Reflection should be even more conscientious when the therapist has made responses from her own frame of reference. Whether there are observable detrimental effects or not, the therapist should question herself as to whether her comments to clients justify the risks—some of which may not be easy to detect.

**Mental Contexts for Therapist-Frame Responses**

There are three particular principles to keep in mind when making therapist-frame responses. First, the therapist does not have expertise or authority about the client’s
experiences. The client is viewed as the best expert about his or her self. Unlike most other therapies, the reasons for therapists’ responses, including therapist-frame responses, are not based on a belief that the therapist knows what is best for the client. There is a pervasive attitude of humility towards the client that is the context for the client-centered therapist’s totality of subjective attitudes.

Second, responses volunteered from the therapist’s frame of reference should be rare. The exception is in responding to clients’ questions. These responses may be relatively frequent because the frequency depends upon the client. The therapist nevertheless maintains restraint in respect to her spontaneous and client-requested explicit therapist-frame utterances. Frequent responses, other than the various forms of acceptant empathic understanding, undermine the distinctive therapeutic processes within the client in client-centered work. Consistent empathic following fosters clients’ self-determination and autonomy.

Third, therapist-frame responses are ideally never systematic. They should not be based on paternalistic, directive, uplifting, religious, conventional or other systematic attitudes that contradict client-centered theory and attitudes. This context for client-centered practice is a motivation to sustain the therapeutic attitudes regardless of the demands being placed on the therapist and regardless of momentary fluctuations in the therapist’s inner experiences.

**Reasons**

There are a number of reasons client-centered therapists may speak to their clients from their own frame of reference. Keep in mind that these reasons do not necessarily justify the behavior in any particular instance. Protection of the client’s self-determination, among other values, may outweigh these reasons in any particular interaction.

1. **Arrangements and Terms of the Therapy:** The most obvious reason for a therapist to represent her own frame of reference to clients is in order to clarify the terms of the therapy. This may be about the fee, the time, the length of sessions, about the extent and limits of the therapist’s services or about the therapist’s expectations of the client. The professional structure of therapy - a client choosing to receive services— requires clear terms concerning mutual expectations, at least to the extent circumstances permit such clarity.

In the context of explanations about the terms of the therapy the client-centered therapist should be as empathically responsive to the client as she is in the other contexts of the therapy. The therapist, for example, may pause after each of her own statements and wait for, or ask for the client’s reactions, and then empathically follow, before moving forward with the next point. The consistent therapist tries to maintain the basic attitudes of respect towards and trust in clients. These attitudes show up in, and influence, all aspects of interaction with clients. While discussing arrangements, the therapist remains oriented to the client with the therapeutic attitudes.

2. **Addressing Questions and Requests:** The most basic reason for a client-centered therapist to speak from his or her frame of reference is to answer, or in some other way directly address, a client’s question or request. Accommodation to a client’s question or request may involve answers, explanations, instructions, descriptions or questions addressed to the client as well as empathic responses.
The actualizing tendency axiom--the basic theoretical assumption, or hypothesis, of client-centered therapy--implies responsiveness to clients in therapy. The axiom logically leads to the fundamental client-centered value of respect for the client as self-determining and the value of trust in the client's self-healing and self-corrective capabilities under favorable psychological and physical conditions. These values, in turn, lead to respect for the client's desire for some kind of therapist-frame communication.6

Respectful responsiveness to questions or requests requires some form of straightforward and non-evaluative response to the client's direction--often an answer or accommodation (Brodley, 1997). Responses to client's questions and requests also involve empathic following responses. In addition to expressing the empathic attitude in this context, empathic responses help the therapist to be certain she understands what the client wants. They also help her to understand the client's reactions to answers or other accommodations.

A client's question or request may be specific to the moment (e.g., what did that look mean?) or it may be a general instruction to the therapist (e.g., please tell me any time, if you have suggestions). It may seek personal information (e.g., how old is the therapist?) or other information (e.g., what different kinds of professionals do psychotherapy?). A question or request may be about the client (e.g., his diagnosis). It may be about what the client should do (e.g., should I take the medication?), about how to do something (e.g., how can I make myself relax before I go to sleep?), about psychological explanations or interpretations of behavior (e.g., why do people get angry when their feelings are hurt?). It may be about the therapy (e.g., what is the theory of this therapy?), and so forth.

Addressing clients' questions and requests is a complex experience and demands much of the therapist. It optimally requires that the therapist be congruent, intellectually clear and that she emotionally accept her own limits. It also requires the therapist to be able to maintain the therapeutic attitudes of acceptance and empathic understanding while being responsive and accommodating to the client.

The therapist's response to a question or request may be a direct answer or it may be one of many other possible responses depending upon the question and upon the therapist's capabilities and personal characteristics. Whatever the factors involved in the specifics of her responsiveness, the basis for answering questions and attempting to accommodate clients' requests remains embedded in the therapist's nondirective attitude. While responding to questions or requests, the therapist avoids attachment to her ideas. She avoids developing expectations about how her client should respond to her. She maintains her respect for, and trust in the client as self-determining in the therapy and with respect to personal choices.
3. **Possibility of a Question:** The client’s narrative or nonverbal behavior may suggest to the therapist that the client desires to ask a question. For example, the client looks up several times expectantly at the therapist. Or he remarks that he’d really like *someone* to tell him what to do in his situation. Rather than wait for the client to explicitly ask a question or make a request, the therapist chooses to inquire about the client’s wishes. This may lead to further responses based on the client’s clarification of what he feels he wants at that point in the interaction.

Regularly waiting until a client explicitly voices a question may mean to the client that the therapist has a withholding attitude. Choosing to inquire, instead of waiting, expresses the therapist’s desire to promote the client’s freedom and spontaneity in the relationship. It expresses the therapist’s commitment to the client as leader. It expresses responsiveness to the client.

Clients often feel inhibited about asking questions or requests. The literature and media of our therapy-culture may have given the impression that the client must solve his problems on his own - he should not ask questions of his therapist. Or the client may have felt punished by a previous therapist when he asked a question. Interpreting clients’ questions or challenging motivations for asking frequently results in clients feeling punished or criticized. The client-centered therapist does not wish to reinforce these inhibiting experiences. Instead, she wishes to communicate respect and support the client’s freedom of self-expression and self-determination.

4. **Empathic Observations:** The therapist may express her perception of an aspect of the client’s communication or emotional expression. These therapist-frame responses are often similar to empathic responses because they attend to the client’s inner world and are usually tentative. They are, however, significantly different in intention and they may have a different impact than empathic responses.

Empathic understanding is an attitude that involves the therapist’s intention to understand a client’s *intended* meanings and feelings. Empathic responses often involve inference because the client’s intended communication is not entirely explicit. The intention behind empathic responses is to understand what the client is intending to express, especially personal meanings and feelings, whether they are explicit or not. An example of a brief empathic response interaction:

C: I go over it and over it but I can’t find a way.  
T: So much fruitless effort feels very discouraging.

The client has not said he is discouraged. The emotion in his words is ambiguous. He could be feeling frustration, fatigue or annoyance instead of discouragement. The basis for the word “discouraging” may be something in the client’s tone or some element in the client’s immediately preceding remarks. The crucial factor is that the therapist tries to understand the client’s intended message. The therapist is not intending to point out or emphasize feelings. The therapist may be correct or incorrect about the feeling. Whether the client confirms the therapist’s understanding or not, the therapist has intended to express her tentative understanding of the client’s intended communication. She has no directive intention when responding.
Empathically relevant therapist-frame comments differ from empathic responses. The comments represent the therapist’s observation of the client, even if she is open to correction. In this way they represent a different attitude than empathic understanding. Sometimes there is no evidence in the client’s words or expressive behavior for the therapist’s inference. Then the therapist may come across as telling the client something about his self—assuming a posture of expert about the client. Sometimes the therapist intends to expand the client’s awareness of his emotions or thoughts— to point out something to the client (not check understanding). The client’s agreement to the therapist’s comment is not necessarily evidence that the element was part of the client’s intended communication. The therapist may have succeeded in enlarging the client’s awareness, as she intended. This may be beneficial to the client in the particular instance. Frequent instances, however, produce a directive therapeutic process and usurp control of the therapy from the client.

In the first moments of the interview with Gloria, Rogers (1966) responds with an observational comment.

   Gloria: Right now I’m nervous but I feel more comfortable the way you are talking in a low voice and I don’t feel like you’ll be so harsh with me.

   Rogers: I hear the tremor in your voice...(p.1).

This response conveys a strong empathic element although it expresses Rogers’ perception. Later in the same interview, in response to Gloria’s assertion that she wants to be “so perfect,” Rogers makes another less empathic therapist-frame observation.

   Rogers: Or, I guess I hear it a little differently - that what you want is to seem perfect (p. 5).

Gloria does not confirm this response. The first type of therapist-frame comment, illustrated by Rogers in response to Gloria is the most benign type. If infrequent, and if they are very close to what the client intended to communicate, they may blend into empathic process such that clients feel well understood. An observation such as the comment in the second Gloria example, that suggests an attitude of therapist expertise, risks threatening the client’s sense of safety in the relationship.

Frequent therapist-frame observational comments stimulate a different relationship with the client. This difference results from the likely impression on the client that the therapist is functioning as an observer of the client. A therapist who observes and who communicates an observing attitude creates a less intimate and less empowering climate. She risks being experienced as distant or as asserting authority over the client’s experience as well as directing the therapy.

Observational responses risk directing the interaction although the client may not be fully aware of the directivity. They are likely to diminish the client’s sense of potency and position in the relationship. On the other hand, occasional empathically relevant
5. **Corrections for Loss of Acceptance or Loss of Empathy or Incongruence:** The therapist does not intend nor wish to deceive her client during instances when she is not consistently experiencing the therapeutic attitudes. At the same time, her behavior does not reveal her true feelings or attitudes. A judgmental reaction to something the client says, or a judgmental reaction to the client's manner, or a loss of full attention to the client, or a disruption in the therapist's congruence, may be only momentary reactions. The therapist may not disclose these experiences to the client because they seem unimportant to the therapist. Perhaps they seem to be instances of the normal variability in subjective life. Or the therapist may not disclose them because doing so would take up the client's focus and time, and distract the therapist from her empathic intentions. Or they might risk a disturbance in the relationship that the therapist does not feel confident she can handle therapeutically.

If inconsistencies in attitude persist, however, the therapist may feel insincere or inauthentic and rightly fear her inconsistencies may be obvious. Persistent inconsistencies are likely to become apparent to the client. The therapist's behavior may come across to the client at least as ambiguous. Consequently, it may undermine the client's focus on his narrative or it may jeopardize his sense of safety in the relationship. Signs of disturbance in the client's attention or in the client's feelings, in the context of deviations in the therapist's attitude, are strong reasons for the therapist to inquire whether the client feels something is wrong. The subsequent interaction may lead the therapist to address her difficulty in maintaining her therapeutic attitudes.

Assuming the client does not ask the therapist what is going on, and assuming there is no sign that the client is aware of the therapist's deviation, the therapist may decide to discuss the problem with a supervisor or colleague. Alternatively, she may choose to disclose her actual experience to the client.

There are two reasons the therapist might choose to disclose. First, she cannot be sure the client does not detect her deviation, even when there is no sign the client is aware of a problem. She wishes to remain entirely trustworthy to her client and not deceive him or confuse him about her attitudes at any time. This appears to have been Rogers' own view late in his life, revealed in a comment to Baldwin (1987).

> When I am with a client, I like to be aware of my feelings, and if there are feelings which run contrary to the conditions of therapy and occur persistently, then I am sure I want to express them. (p. 46)

A second reason for a self-disclosure when the therapist has deviated from the therapeutic attitudes, is to talk out the problem with the client. The hope is that doing so will restore the therapist's experience of the therapeutic attitudes. If the problem has been one of the therapist being distracted from the client, the interaction acknowledging the distraction may immediately restore the therapist's empathy. If the problem has been a judgmental reaction-- a loss of acceptance-- concerning some aspect of the client or his communication, the interaction may lead to new understandings and dispel the judgement. Or, the therapist's confession and the subsequent interaction may give the
client perspective on the therapist's feelings. Perspective on the therapist's judgments or distractions may allow the client to better trust the therapist's authenticity. At the same time, of course, it may jeopardize the client's sense of safety in the relationship.

The therapist's manner, and the form of self-disclosure to correct for slips in her experience of the therapeutic attitudes make a great difference for its impact on clients. This is true especially if the disclosure involves a disagreement with the client, or feelings of disapproval about the client. Rogers' corollary to congruence (1961) offers partial guidance concerning the form of communication. Self-disclosure should be a congruent communication. He proposes that congruent communications must be expressed as personal perceptions, not assertions of fact. (See the discussion in Brodley, 1998b.) In addition, the therapist's sensitive empathic understanding of all of the client's reactions to the disclosure helps to prevent serious disturbance in the relationship.

6. Insights and Ideas: The client-centered therapist occasionally may speak from her frame of reference when she has an insight or idea that fits into what the client is exploring or trying to understand about his experience. This is least threatening to the client's autonomy and self-determination when the client has earlier mentioned he wants to hear the therapist's perspectives from time to time. The contents of the particular moment appear to fit the client's expressed interest in hearing the therapist's ideas or perspectives. Because the client's wishes at the moment are unclear, it is wise to ask the client if this is a time when he would be interested in the therapist's thoughts. This kind of action shifts the control back to the client even as the therapist has intervened and usurped control.

Or, the therapist may feel inspired to say something she imagines might be helpful to the client. In this case there has been no prior request from the client for such material. She does not know at all whether or not the client would wish to hear from the therapist's frame. The therapist might ameliorate the directive impact of her intervention by acknowledging she would like to share her idea or perspective. She might ask if the client wishes to hear what the therapist is thinking. These steps of inquiry temper the impact of impulsive directivity. They tend to shift control back to the client. Consequently, the client is more likely to continue to feel self-determining in the therapy process. Therapists should not delude themselves that there is no detrimental effect on the therapy because the client expressed interest in, or made constructive use of, therapist-frame comments.

A particular problem in the two situations has to with whether the client can understand the therapist. The therapist's remarks should be succinct. She should pause to allow the client to ask a question or make his own remarks, as the therapist unfolds her idea. If there are explanations or interpretations in her idea whose source is not obvious, the therapist should spell out her data and the logical steps leading to the idea. In being clear about the underpinnings of her ideas, the therapist is sharing power with the client even while introducing her own material.

7. Emotionally Compelling Circumstances: Spontaneous therapist-frame responses may emerge from the therapist's feelings and emotions. The therapist expresses them without having prior rationalization for them, and without the intention to appear authentic nor make any other impression on the client. They are impulsively emitted.
One category of spontaneous therapist-frame emotional response is that of emotional utterances that are reactions to emotionally compelling circumstances reported by the client. Some events have relatively compelling social meaning which lead to common socially patterned emotional responses. For example, the therapist says: "Oh, No! I’m so sorry" when told that the client’s child has been hurt in an accident. This kind of response reveals that the therapist is engaged in the relationship in a personal manner... that she is emotionally present and responsive to basic human situations.

Such responses have hazards. An emotional reaction almost always implies a value and it might well be that the particular client’s feelings or values are quite different than those implied by the therapist’s emotional reaction. The therapist reacts with “Oh, No!” to the information that the client’s brother was beaten up. It turns out that the client feels his brother deserved the punishment. The therapist’s emotional utterance may immediately place the client at odds with the therapist or stimulate the client to feel the therapist may judge him critically.

8. **Prior Information:** Other special circumstances leading to spontaneous emotional responses from the therapist’s frame are ones which are based on something the client previously has said is specifically important to him in a positive or negative way. For example, the client reports that he has finally telephoned a girl he is attracted to in the context of having spoken at length in the past about being unable to take that initiative. The therapist spontaneously responds “great!” The hazards are less in this category, because the client has previously shared the feelings and value. On the other hand, the client’s feelings may have changed and the therapist’s reaction may contradict the client’s immediate emotional direction.

9. **Spontaneous Agreements.**

Another form of spontaneous response is an *agreement* with the client based on compelling or very common knowledge. For example, the therapist says “that’s true” when the client says it is too late to change the legal contract he has signed. Rogers’ demonstration interview with Peter Ann (1985) includes an agreement response. The client wants to have a baby after losing her twins.

\[ \begin{align*}
C1: & \quad \text{I suppose all I can do is keep working at it.} \\
T1: & \quad \text{Mhm, hm.} \\
C2: & \quad \text{’Course then there’s a biological time clock. And so not everything is in my corner.} \\
T2: & \quad \text{That’s right (p.10).}
\end{align*} \]

These common knowledge type agreements are usually benign-- their grounds are obvious to clients.

10. **Evaluative Reactions:** Another form of spontaneous response from the therapist’s frame may be a comment that voices an opinion, judgment or evaluation. The risk of harm to the therapy relation is somewhat higher in this category, than those described above.
Expressions of opinion, etc., may damage the therapy relation by raising the specter of evaluations about the client. Among evaluative possibilities, evaluative reactions to something or someone other than the client are least likely to damage the therapy relationship although they too involve the risk. For example, the therapist remarks “How rude!” in response to a client’s description of how someone at the client’s workplace acted towards another person. Although intended sympathetically, the client may feel he has done worse on other occasions and feel the therapist would disapprove of him if she knew.

Spontaneous emotional reactions, opinions, judgements or evaluative remarks all entail risks to clients’ sense of safety with their therapists. In addition to breaking the empathic process of interaction, they tend to raise or reinforce the client’s expectations that the therapist is evaluative, especially that she is judgmental about the client. This impact occurs even if the particular remarks are not about the client. Frequent evaluative remarks are detrimental to the client’s perception of the therapeutic conditions.

Occasional spontaneous responses are natural to client-centered work as a consequence of the therapist’s relaxed and responsive presence. They are also naturally limited in frequency because of the strong influence of the therapist’s nondirective attitude and the therapist’s discipline in maintaining the therapeutic attitudes. Spontaneous responses take place in the context of and are qualified by the therapist’s non-directive attitude and commitment to unconditional positive regard and empathic understanding. These basic features of client-centered work produce a natural restraint and reserve. They do not, however, rigidly prohibit the therapist’s emotional or spontaneous expression. Occasional therapist emotional reactions reveal the therapist’s empathic involvement and spontaneous presence. The therapist wishes to be spontaneous while not getting in the client’s way.

11. Impulses to Exteriorize: There is another category of therapist-frame responses that is similar to the emotional, spontaneous types. These responses are also not reasoned out beforehand. Nor are they intended to produce an effect. They do suggest to the client that the therapist is willing to be transparent – to be known. One type is a disclosure expressing a therapist’s interior thought that would usually not be disclosed. Rogers’ demonstration interview with Ms. G (Merry, 1995) includes an example (in the parentheses of T4) where Rogers speaks out loud to himself.

C1: I always feel guilty when I’m crying. And I always feel as though I’m not allowed to cry.

T1: Mhm, mhm. Mhm mhm. um...”Don’t cry. Be a big girl”.

C2: Yeah.

T2: But when the tears were dropping, it was the four year old, feeling very hurt.

C3: [Pause 25 seconds] And angry, very angry.
T4: And angry at them. (Can you say that? Then I thought maybe not.) Angry too, um hum. “Damn you. Why don’t you consider me?”

C5: [Nods agreement].

The second are Rogers’ “intuitive” responses. Rogers (1986b) refers to them as follows: “...I may behave in strange and impulsive ways in the relationship, ways which I cannot justify rationally, which have nothing to do with my thought processes.” (p. 199).

Exteriorizing responses of this type may consist of speculations, interpretations, metaphors, visual images, associations, or fantasies that come to the therapist’s mind. They may be obviously related to the client’s remarks or not – but they occur in the context of the therapist’s empathic immersion in the client’s presented world of experiences, ideas and feelings. Idiosyncratic responses, described by Bozarth (1984), appear to include this category.

The therapist is likely to be surprised by her own exteriorizing utterances. She may couch these responses in an almost apologetic manner. They are certainly tentative in regard to relevance to the client. Rogers (1986b), for example, prefaced one such response with the remark, “…this may seem like a silly idea...” (p 206).

Sometimes these exteriorizing types of therapist-frame responses stimulate the client towards new awareness. The client also may express appreciation to the therapist for the remark. The fact that they are appreciated and that they seem to promote some good productivity in the client does not validate such responses in general. The therapist should realize that the constructive use clients may make of exteriorizing responses (or any other therapist-frame responses) may not be the result of the therapist’s genius or sensitivity. Clients may accept, use and appreciate such responses because they are inclined to accommodate or be compliant with therapists.

The client’s constructive use or follow-through in reaction to the therapist-frame response has probably changed the direction of the dialogue. Productive as it may be for the client in the moment, it at least briefly undermines the client’s directive potency in the interaction. Frequent therapist-frame responses that constructively stimulate the client result in a therapist directed therapy -- a different kind of therapy.

12. Correcting Misunderstandings: Another reason for making therapist-frame responses is when the therapist experiences the need to correct a client’s misunderstandings about the therapist. The therapist may initiate a correction if the client has wrong ideas that could affect the client’s perception of the attitudes, or influence his expectations about the therapy. A common reason for this type of response is that the therapist needs to clarify his or her limitations in respect to the services being offered. For example, the therapist cannot be available for between-session long telephone calls. But, the client has made a remark that suggests he believes he has unlimited telephone access to the therapist.

One problem for the therapy in making corrections is its risk to the client’s feelings of safety in the relationship. The client may perceive the therapist as criticizing him for his mistake. Another problem is that the correction may involve disappointment for the
client. The client may not be able to voice his reactions to either of these problems. The client sustains a negative emotional experience that the therapist may not perceive. It is probably wise to ask the client for their reactions to corrections if the client does not volunteer them. This inquiry may provide an opportunity to correct for any unfavorable impact of the corrections.

13. The Therapist Is a Source of Information: Clients have a reasonable expectation that therapists will provide them with any important information that may be relevant to their problems. This information might be about outside resources that may be appropriate and helpful to the client in pursuing his emotional well-being or other self-defined personal goals. The therapist legitimately functions as source of information for the client in respect to help for his pain or other concerns that may not be fully resolved by psychotherapy. For example, the therapist may introduce the idea of the use of psychotropic drugs for alleviating certain symptoms. Or the therapist might know of community services that address the client’s particular rehabilitation needs.

Providing information (especially when it has not been specifically requested by a client), however, involves the same risks of misunderstanding and counter-therapeutic impact as other therapist-frame responses. Suggesting the possibility of medication, or suggesting a behavioral technique for allaying anxiety when speaking in public, for example, may have countertherapeutic implications for a client. The client may perceive a suggestion about using medication as implying he is mentally ill. The client may think of techniques as an extreme burden and the therapist consequently seems insensitive to him. Information that has been offered, also, may be perceived as the therapist’s expectations. The client must follow through or disappoint the therapist. The multitude of countertherapeutic misunderstandings that may arise from therapist-frame responses, without the therapist’s immediate knowledge, should not be minimized.

Discussion

Something that may stand out to readers familiar with other kinds of therapy is the absence of generating information from clients as a reason for responding from the therapist’s frame. Client-centered therapists almost never ask leading questions. Empathic understanding interactions serendipitously generate a great amount of information about clients. Client-centered therapists are not therapeutically interested in information about their clients except as the clients are inclined to disclose it. Pursuit of information through leading questions is one of the major methods therapists may employ to direct a therapy, which client-centered therapists do not wish to do. This kind of therapist sincerely wishes to avoid directing the therapy.

The reader may also have noticed that confrontation to provoke insight is not given as a reason for therapist-frame responses. Insight is not viewed as necessary for therapeutic change in client-centered therapy, although often it is a part of the process. Confrontations express an attitude of therapist expertise over the experience of the client. In client-centered work, a therapist may be puzzled by a client’s reasoning, motivations or behavior. The puzzlement may lead to a question for clarification. Unlike confrontations, the attitude that brings forth a question for clarification is not adversarial, nor is it based on the therapist’s authority in the relationship. Questions for clarification express an empathic attitude—wanting to understand from the client’s frame of reference.
Congruence, also, is not included in the list of reasons for therapist-frame responses although it is cited as a reason by some person-centered therapists. Congruence is not a logical reason for such responses because it is a condition of the therapist defined in terms of a relation. Communications may be congruent. Congruence is an important qualifier of the character of therapist-frame communications, but there must be some other basis for making the utterance. (See Brodley, 1998 for further discussion of this issue.)

Several of the reasons a client-centered therapist may make responses from her own frame of reference, (reasons numbered 7, 8, 9 and 10 above), are based on the fact that the therapist is foremost a person in a social situation. Great deviations from the common norms of participation in an interpersonal relationship may be perceived as artificial, insincere or manipulative. Avoidance of minimal social interactions may make the therapist appear distant or rigid. These qualities may seem ambiguous and stimulate a client to interpret the therapist as judgmental or unempathic. Answering “I’m very well thank you” to the client’s “how are you?” shows in part a respect for the social nature of the therapy situation. It is responsive to a client’s reasonable expectations of courteous treatment. Such minimal social responsiveness takes up very little space in the therapy setting and normalizes the situation.

In normal social intercourse, people usually respond to others from their own frame of reference. Their responses involve or assume some degree of intake of the other person’s remarks and feelings. Social conversational responses typically include agreements, disagreements, emotional reactions or elaboration of the other person’s remarks. Also, responses in social situations are often non-sequiturs. Explicit empathic understanding responses are a rare part of typical social communication behavior.

Certain kinds of therapist-frame statements, although they are tempered by restraint, may give a quality of naturalness and authenticity (as contrasted with role playing or mouthing a technique) to the highly specialized therapeutic situation. Valid as this point may be, it requires careful qualification given that client-centered is an expressive, not instrumental, therapy (Brodley, 1997).

The expressive character of client-centered therapy affects the intentions that underpin responses from the therapist’s frame of reference. A sprinkling of remarks from the therapist’s frame probably enhances the flow of interaction and increases the appearance of a naturalistic conversation. This idea, however, does not imply that the therapist should deliberately make such remarks to produce an appearance. Such a deliberate and systematic intention is in conflict with the spontaneous and expressive character of client-centered work.

The rationale for allowing a sprinkling of remarks from the therapist’s frame is similar to the basis for adjustments to individual clients (such as to the client’s vocabulary) for the sake of comprehensible communication. It is an element in the therapist’s back-of-the-mind understandings of the complex role of client perception in the therapeutic situation. Many such understandings influence therapists’ adjustments to their individual clients. It is a facet of the personal and psychological complexity of the therapy relationship.

Recall that Rogers’ theory (1957; 1959) asserts that therapeutic efficacy requires the client’s perception of the therapist’s empathy and acceptance. It is an implicit feature of this point in the theory that the client’s perceptions of the therapist as sincere and transparent are
necessary for the client to experience the greatest benefit from his perceptions of being empathically understood and accepted. Certain kinds of therapist-frame non-systematic communications may contribute to the client’s perception of the therapist’s authentic and sincere presence.

Without deliberate or manipulative intentions, the client-centered therapist must project her presence as an authentic person in the relationship in order to be most effective. This is in contrast to projecting a role-playing presence. What are the behaviors that contribute to an authentic or sincere presence in the therapy? The basic way client-centered therapists communicate their authenticity is through their sincere empathic and accepting attitudes. These shape tone, manner, and gestures as well as words. A therapist’s presence of realness or naturalness also may be enhanced by spontaneous utterances from her own frame.

Responses from the therapist’s frame involve putting aside, at least momentarily, the empathic focus that is the essence of the therapy. It should be understood to involve risks of being misinterpreted, and risks of undermining the client’s sense of safety or self-determination in the therapy relationship.

Conclusion

Thirteen reasons for therapist-frame responses have been proposed. They are: 1. Arrangements and terms of the therapy; 2. Addressing questions and requests; 3. Possibility of a question; 4. Empathic observations; 5. Corrections for loss of acceptance or loss of empathy. 6; Insights and ideas. 7; Emotionally compelling circumstances. 8; Prior information, 9. Agreements; 10. Evaluative reactions; 11. Impulses to exteriorize; 12. Correcting misunderstandings; and 13. Source of information. Listing and describing these reasons is not identical to asserting that the responses are good for a client or for the therapy process. Reasons are not necessarily justifications or adequate rationales for the behavior. Mindfulness about the essential therapeutic features of client-centered work and awareness of the complexity of client’s perceptions, and their probable vulnerabilities, should over-ride temptations to casually represent the therapist’s frame.

All of the reasons client-centered therapists may occasionally communicate from their own frame of reference with clients assume that the therapist tries to remain congruent-integrated— in the relationship. The reasons given also assume that the therapist continues to acceptantly and empathically understand the client and communicate empathy throughout the ensuing conversations. Therapist-frame responses explaining the terms of the therapy are necessary. The frequency of responses to client’s questions or requests depend upon the frequency of these things coming from the client. Other therapist-frame responses should be infrequent. If they become frequent, they are probably systematic— the therapist has a persistent directive intension. She has some agenda or goal for the client or an inappropriate goal for herself. The therapist then has stepped outside the parameters of client-centered work.

My effort has been to clarify some possible reasons for responses from the therapist’s frame in client-centered work. I hope I shall not be misunderstood as intending to encourage them. Client-centered therapy is a nondirective therapy that protects a client’s self-determination in the relationship. It succeeds when practitioners experience the attitudes, are capable of implementing them appropriately with the particular client, and are faithful to the basic premises and theory. For the most part, this means (a) the therapist is trying to
understand-- her attention is focused on acceptant empathic following of the client; and (b) the therapist explicitly checks with the client to find out if her inner understandings are correct.

There is some latitude for various forms of verbal (as well as non-verbal) expression of the therapist as a person in social interaction with another person-- representing his or her own point of view-- or as an expert or informant in certain matters. But these functions are secondary and neither necessary nor sufficient for effective client-centered practice. As Patterson (1990) states about client-centered therapy: "There is some freedom. But there are limits. The freedom of the therapist stops when it infringes on the freedom of the client to be responsible for and direct his own life" (p. 431).

It is not easy to avoid infringement on the client's freedom. Appropriately protecting the client's freedom is a subtle and complex process. The therapist needs freedom to function spontaneously and naturally in the relationship. The therapist's freedom involves risks to the client's freedom as well as his sense of safety.

The reader may grant the general validity of the reasons I have described for client-centered therapists to respond occasionally from their own frame of reference. At the same time, it should be realized that the loss of the client's sense of safety and the loss of the client's freedom are much more likely, even in unexpected ways, when we respond from our own frame of reference.

Notes

1 "True" empathic understanding responses reveal some facet of the person or self of the client. They express, at least in part, the relation of the self to what the person is talking about. They include some element of the client as an agent. They reveal the client's dynamic-- his feelings, his reactions. Or they reveal his adience to or avoidance of something or someone. Informational responses are also part of empathic following behavior. These responses attempt to check with the client about the accuracy of the therapist's understanding of the information that the client is narrating. Informational responses do not include the element of the client's self in relation to the information but they are part of empathic following of the client. Questions for clarification are also part of empathic following behavior. They are questions about what the therapist has already perceived as within the client's expressed frame of reference. Questions for clarification are easily distinguished from leading or probing questions.

2 Rogers also spoke from his own frame of reference in responding to questions asked by his clients. He answered questions or in other ways responded respectfully from his own frame. Spontaneous responses from the therapist's frame of reference are, by definition, unsolicited by the client.

3 My guess is that a mean percent of over ten to twelve percent of therapist-frame responses (other than therapist-frame responses to clients' questions) in a fair sample of a therapist's cases probably casts doubt on the therapist's consistency in being client-centered.

4 Presence refers to the totality or amalgam of the therapist's personal features and behaviors, along with their emotional or affective qualities, that are perceptible to the client.
Presence as a personal self in client-centered therapy is thought to be crucial for therapeutic effect (Rogers, 1980; Brodley, 1999).

Client-centered work with self-expressive, narrating clients involves a dominance of empathic understanding responses—usually 90% to 100% apart from responses to questions. Certain clients do not provide communications to therapists that permit informed empathic responses. Clients who appear to be out of contact, or those who are completely silent, or young children in play therapy—often require empathic guesses based on the environment, previous understandings shared by the client, or the client’s nonverbal behavior. Work employing empathic guesses may be no less client-centered, depending upon the circumstances.

There may be, of course, situations when the therapist chooses to not answer a question or not accommodate to a request. In client-centered work, refusals to honor the client’s direction are not based on the therapist’s judgement of what is good or bad for the client except in rare circumstances, such as occasionally with children. The therapist’s reasons for refusals tend to be personal preferences or his limitations. The therapist always has the right to refuse to answer a question or cooperate with a client’s special wishes.

REFERENCES


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