

The Difference Directiveness Makes: The Ethics and Consequences of Guidance in Psychotherapy

Marge Witty

Illinois School of Professional Psychology
Argosy University-Chicago

Abstract

Non-directiveness is an attitude of the client-centered therapist. It is the valuational matrix within which the core conditions of acceptance, empathic understanding, and congruence coalesce. The paper explores how departing from this attitude makes a difference in clients' experiences of psychotherapy. An excerpt from focusing-oriented therapy suggests effects of directivity that re-inscribe the authority of the therapist and undermine clients' "power to refuse." It is argued that non-directive client-centered therapy trusts clients as the proper architect of the therapy process and that process directive and experiential therapies do not.

The Rationale for Non-Directiveness

Rogers' Motivational Theory

The theory and practice of non-directive client-centered therapy is unique among therapeutic approaches. It stands alone in advocating that the therapist be committed to principled non-directiveness (Grant, 1990) while providing the core conditions for personality change: congruence, empathic understanding of the client's internal frame of reference, and unconditional positive regard. A non-directive relationship proceeds logically from a view of the client as an autonomous person. It is an extension of Rogers' theory of motivation, which postulates an actualizing tendency that animates and organizes all activities of living organisms (Goldstein, 1939, 1940; Rogers, 1951). The actualizing tendency functions holistically and constantly in the lives of organisms from birth until death. Human beings are evolving processes moving toward greater differentiation and complexity; their aims and purposes, while not random, are unpredictable.

Author Note: If Barbara T. Brodley had not raised the issue of the distinctions between experiential and client-centered therapy, it is unclear to me whether a genuinely non-directive school of client-centered therapy would have survived (although this may be unfair to some practitioners in Europe who are committed to a non-directive approach.) At the time I took the practicum at the Chicago Counseling and Psychotherapy Center in 1972, client-centered therapy was taught in a highly oversimplified, shallow way as a kind of active listening. None of the staff at that time transmitted what I now understand to be client-centered therapy.

Rogers' Ethical Philosophy

The non-directive attitude is consistent with Rogers' view of persons' capacity for self-direction. The attitude is equally well described as an expression of Rogers' *valuing* of persons' *right* to self-direction (Bozarth, 1998; Brodley, 1997, 2002; Grant, 1990; Rogers, 1942). In attempting to live this ethical position, the client-centered therapist must consider the autonomy and self-regard of a client in every aspect of the therapeutic relationship. A collaborative relationship maximizes the potential for clients to become, in Raskin's (1988) words, the "architect of the therapy" (p. 2).

Efficacy in and of itself can never justify psychotherapy. If we believe in meeting clients as sovereign persons, the only process that does not preempt their self-determination is that of empathically understanding their intentional communications (Grant, 1985; Schmid, 2001). Any systematic process-directivity, intervention, or procedure that does not emerge from clients' creative participation in the relationship violates principled non-directiveness. From a client-centered point of view, we are constrained by our commitment to an attitude of principled non-directiveness by respect for the *voice* of the client, the intentions of the client in the therapeutic situation (Grant, 1985, 1990). We are bolstered in this attitude by our belief in the functioning of the actualizing tendency of clients, who are seen as having vast, untapped resources for meeting life and life's difficulties. But whether or not we accept the actualizing tendency as the sole motivation in organismic life, we cannot evade the ethical commitment to non-directiveness if we wish to interact with a client as another sovereign human who is at all times both capable of and deserving of free expression and self-representation.

Experiential and Process-Directive Therapies

Method vs. Expression

To describe the client-centered approach as a *method* among other therapeutic methods is to misunderstand it. As Schmid (2001) puts it, "In person-centred therapy, the attempt to understand is never used 'in order to'" (p. 53). From a client-centered viewpoint, we are not using a "means" like empathic understanding of clients' meanings in order to achieve "ends" such as "directing attention to internal experience," or "intensifying the client's feelings." We are not "using" ourselves as therapeutic agents to enhance the client's "experiencing process." The practice of client-centered therapy involves expressiveness from both persons in the therapy relationship (Brodley, 2002). Client-centered therapists do not direct clients' ways of being in therapy: They do not direct how clients go about the relationship or the processes or contents they engage in or express within the relationship.

In my reading of the studies assessing the relation of early-in-therapy experiencing levels to outcome, there is insufficient evidence to support the idea that a particular kind of process, high levels of focused experiencing, necessarily leads to superior psychotherapeutic outcome (Brodley, 1988, Zimring, 1997). But, crucially, even if evidence were to accrue to support an optimal mode of clients' "processing" and an optimal mode of therapists' functioning, we would not be compelled to train that process in clients who did not spontaneously manifest it. Client-centered therapists aim to

participate in a relationship in ways that respect and honor clients' unique perceptions, meanings, and purposes. We regard directiveness in regard to clients' internal processes (which we cannot know directly) and expressions of meanings as presumptions and encroachments upon the autonomy of clients that undermines their experience of the validity of their frames of reference.

Clients in psychotherapy are (or should be) free to define the experience in any way they want. They may feel that they are there to get an "objective view of the problem." They may assert a need to be "healed." They may want to be helped to "get in touch with feelings." They may be quite inarticulate about what brings them to therapy and why they stay there, even over long periods of time. We assume that clients want to be understood when expressing intentions or hopes or vulnerable feelings, or complaints about us or about the therapy process. The willingness of the client-centered therapist to respond to expressions of meaning with empathic understanding *absent any other intention* distinguishes client-centered therapy from therapies which have *a priori* notions about what is "good" to *do*—notions that have arisen from sources external to the client. Rogers was keenly aware of environmental influences and constraints. He was hardly naive about the extent to which some persons must cope with environmental circumstances that limit realization of the press for actualization. Our clients come to us with myriad received conceptions about who they are and what they are like, internalized from family, school, media, religion, and sometimes, psychology and psychiatry. The conceptions may help, but often hinder their organismic experiencing and self-creation. Our work is not to counter, rebut, or interpret these influences or to educate clients, but to realize the therapeutic attitudes and to be experts on not being experts. Schmid (2000) states:

For the person working in the person-centered field, the realization of these basic attitudes, which at the time has to be newly put into effect during the process, represents *the help, which needs no supplementation by specific methods and techniques reserved for the expert*. "Expertism," if it has been described, lies exactly in the ability to resist the temptation of behaving like an expert (even against the client's wishes)—that means, solving problems with the help of techniques rather than facing them as persons. (p. 15, emphasis added)

Appropriating client-centered therapy and the empathic response

Polanyi has pointed out that unlike scientific experiments, which aim to be replicable across time and contexts, "[a]n art which cannot be specified in detail cannot be transmitted by prescription, since no prescription for it exists. It can be passed on only by example from master to apprentice. . . . It follows that an art which has fallen into disuse for the period of a generation is altogether lost" (Polanyi, 1955, p. 53). Non-directive client-centered therapy is a practical art in danger of being lost. A significant factor in its possible demise are claims that it has been absorbed within and improved upon in more "evolved" experiential and process-directive therapies.

Gendlin argues that experiential therapy is a more highly evolved therapy—a method of methods—whose origins are the old, "classical" approach advocated by Rogers, improved on both philosophically, with better "process" concepts, and practically, with more efficacious, potent ways of stimulating high levels of focused experiencing (Gendlin,

1974, 1996; Hendricks, 1986). Gendlin's writing has contributed to a reductionistic stereotype of client-centered therapy as simply "active listening." Gendlin (1974) does hold client-centered "listening" in high regard as the "baseline" to which any therapist of *any* orientation should return. He asserts that therapists can do anything as long as they return to the baseline, clients' experienced "felt sense" (p. 211).

Describing empathic understanding as "listening" or as a "baseline to return to" implies that this response form is a *tool* employed by therapist to get clients back in touch with the "felt sense" they are attempting to symbolize. Gendlin and Hendricks believe that focused processing *is the original source of all meaning, so that to prompt clients to focus upon felt sense is simply to return their attention to their bodies, out of which all meanings arise.* They seem not to take criticisms of their directivity very seriously, rationalizing focusing prompts and direction of the process as simply being in the service of returning clients to their personal authoritative, original source. Experiential and focusing-oriented therapists claim that they have no wish to direct clients or to exert any kind of expertise; they simply want to help persons' nascent expertise in their own experience to emerge. However, the absence of motives to have power over the client does not insure that the client experiences being prompted and guided in "processing" as neutral or non-judgmental or empowering.

Focusing-oriented therapists make a judgment that current "pre-focusing" ways of processing or symbolizing experience is not as productive, accurate, intricate, or rich as the symbolizations that emerge from "clearing a space," "focusing upon the felt sense," and getting "felt shifts" or "referent movement." Focusing-oriented and process-directive practitioners are necessarily displacing the natural manner in which clients speak, communicate, and attend with a guided process of steps. There really is no return to baseline once this process has been inculcated in a vulnerable client. The training process has changed the way clients can be in the therapy.

Gendlin viewed successful therapeutic personality change as resulting from a particular form of focused experiencing, not as a consequence of a particular kind of human relationship. As Prouty (1999) points out, Rogers clearly viewed the therapist's provision of a *relationship* with particular attitudinal qualities, informed by ethical principles of the trustworthiness of persons and respect for persons, as the necessary and sufficient condition for personality change. Experiential and process-directive therapies locate the cause of change in a particular kind of internal processing in the client. The therapist's attention is on the client *as a whole person*, but is directed toward the client's experiencing process, or in the case of emotion-focused therapy, toward "bringing about effective client processes" (Greenberg & Paivio, 1997, p. 280). Gendlin (1974) states:

The experiential method . . . is a way of using many of the different therapeutic approaches. It is a method of methods. It enables me to show just how client-centered therapy ought to be a part of every therapist's way of working. It is a *systematic way of using various vocabularies, theories, and procedures, among them client-centered therapy.* When I have offered some details of its theory and practice, it will then become clear how my rendition of client-centered therapy . . . is really a reformulation of it in experiential terms. As so reformulated, it ought to be a part of every therapist's way of working. (p. 211, emphasis added)

Gendlin construes client-centered therapy as an instance of “vocabularies, theories, and procedures.” He asserts that any therapist, regardless of orientation, can benefit from incorporating “reformulated” client-centered therapy as if client-centered therapy were synonymous with “listening.” It is clear that Gendlin abandoned the fundamental premise of the approach in favor of a *method* that fosters focused experiencing in the client. Empathic understanding responses are accorded value, but criticized: “Today, looking back, I think that 90% of the client-centered therapy I have seen in the last two decades was only round approximation. The client’s distinctively felt experience, rather than being articulated, was obscured and deprived of its specific edges by such responding” (Gendlin, 1974, p. 214).

“Listening” responses, to be facilitative, must be accurate, and must be constantly checked by the client against “what is there.” Gendlin offered this as a rule for the new experiential listening. He claims that experiential therapy is a “new” way, an evolution from the “old” way of client-centered therapy, which retains the basic client-centered attitudes. However, as I argue here and Brodley (1990) argued elsewhere, the shift to focusing-oriented therapy is quite clearly a departure that changes the nature of the therapy relation.

Critique of a segment of a focusing-oriented session

Gendlin (1964) departed from the theory of client-centered therapy when he posited *experiencing level* as the independent variable, the motor of change, in any therapy. He created a form of therapist response called “the experiential response,” which is intended to invite attention to the bodily felt sense and facilitate a carrying forward of experiencing. Experiential therapists claim they are non-directive because they drop the invitation to attend to the bodily sense if clients do not want it. But it is hard to imagine how empathic responses that are given along with invitations to focus cannot create a *different kind of relation between client and therapist* and change process and content. Even when invitations are given with utmost respect and sensitivity, clients cannot help but conclude that the focusing-oriented therapist has a conception of what is helpful and what is not, particularly if they are frustrated with their way of being in the therapy. And in fact, process-directive therapies *do* have a conception of what is effective and ineffective therapy behavior in clients.

In transcripts of focusing oriented therapy, there are clear instances in which the attention of the client is guided away from the therapeutic relationship to the client’s “body.” Here is an example from Gendlin (1996):

- C: (*After he has talked unemotionally for some time, there is a break in the client’s voice.*) I’m so tired of my depression, and other people also get very tired of it. My friend Nick got tired of it and he doesn’t want to see me now, much. If I go to his place I try not to complain and ask for care. And in my group they said I’m passive and all I do is complain. I do say to myself: ‘I can take care of myself. I can do that myself.’
- T: You can sense that the depressed feeling *is* wanting care, and you do kind of give it to yourself. It scares you, though, that the people are getting tired of you.
- C: And I’m worried that you will too.

T: And that includes me. You're scared I'll get tired of you being depressed and asking for care.

C: Yes. (*Silence*)

T: I notice *something welling up in you* when we talk about your needing care.

C: Yes, it loosened things in my throat. Mostly I don't feel anything.

T: Saying you need care loosens your throat, *and you do really feel that wanting, wanting care.*

C: It loosens that locked place. (*Eyes tear up*)

T: *Do sense that now as clearly as you can in your body*; the stuck depressed place is really this need-for-care place. Is that right? Can you sense that?

C: It loosens when I say 'I need care,' and *if somebody is there to say it to*. And it's also the connection with all that stuff with my mother that we talked about.

(p. 187–188, emphasis in the original, underline added)

This short segment of focusing-oriented therapy illustrates several significant points. First, we note a “training effect” in the client’s statements: “It loosened things in my throat” and “It loosens that locked place.” In my practice of client-centered therapy over the last 30 years, I have rarely heard clients spontaneously give such “status reports” about their bodily responses. In a recent session, one of my clients said, “My mother’s words stabbed me in my heart!” as she put her hand to her chest. This is a very different statement from “I have a clenched feeling in my chest.” Statements such as “It loosened things in my throat” give the impression of an outside observer reporting on the status of a body region. I am distinguishing these “report” statements from directly expressive statements that are not literal descriptions. I believe that focusing clients are taught to report these bodily “sensings” and to *award them significance*. It is also of interest that the report about the client’s loosening throat occurs as a response to the therapist’s observation that “something [is] welling up in you.” It is not clear what the therapist was attending to; it is stated as if it were an observation—“I notice.” Since the therapist does not mention data that supports the claim, the client presumably searches for what was “welling up” and reports about his throat. Although this was probably not the therapist’s intention, the “observation” trains and directs the client’s attention to bodily data. The report is not merely a physical description about phlegm loosening, but is a metaphorical use of the term “loosening,” implying “something is happening,” and evidences a training effect. It is possible that the next sentence—“Mostly I don’t feel much of anything”—is the client’s way of resisting the therapist’s pressure as he recognizes that he is complying with the therapist.

At the juncture in which the client has the courage to acknowledge his fear that the therapist will tire of him, the therapist gives an empathic response, but then breaks the silence by making a personal observation that has the effect of deflecting the client’s attention from the here-and-now with the therapist to his own bodily state. In this example, the therapist has a goal for the client that is clearly shown in the imperative instruction: ‘Do sense that now as clearly as you can in your body.’ This instruction is followed by another statement from the therapist’s frame—that the “stuck depressed place” *is* “really this need-for-care place.” The therapist relates caringly *and* authoritatively in conveying the impression of knowledge of what the client should do in the moment and what the client’s experience of being depressed is *really* about.

This interaction is quite different from what might have occurred if, after the uninterrupted silence, the client had said, "I need you to care for me." The client may or may not have made such a daringly direct appeal to the therapist, but the point is he was not given the chance. His attention is diverted away from the relationship and toward events supposedly occurring internally. Instead of a moment of authentic encounter, there is a procedure offered to the client in which he *must as clearly as he can* sense what the therapist suggests: that the stuck, depressed place *is* the need-for-care place. The client concurs with this new formulation, saying, "It loosens when I say 'I need care' and if somebody is there to say it to." It is interesting that at no point has the client actually said to the therapist "I need care," rather that when he says it— to himself or the world at large (we don't know who he addresses), his throat loosens "if somebody is there to say it to." The statement almost strikes one as a hypothesis he is testing. It is how this works in him; it is not a direct, personal interaction. By way of contrast, a personal interaction might take place as follows:

- C. I want to say to you that I feel that I need care. . . . I need *your* care.
T. You're feeling that need for caring in general, but also in this moment from me.
C. Yes, that is true.
T. You do *have* my care. I really do care for you a great deal.
C. Thank you for saying that. I appreciate that so much.

Ethics and Consequences of Direction and Non-Direction

Iatrogenic effects of therapeutic goals

Non-directive client-centered therapists believe that the only goals we should have in therapy should be goals for ourselves in learning how to realize the attitudes, not only because clients' right to self-determination should constrain us, but also on the belief that *constructs*, such as "experiencing," "conditions of worth," or "felt sense" are most often *not* expressions of clients' frames of reference. We are mindful of how easily clients can take on the views and vocabulary of the therapist, even when the therapist tries to eschew this influence. Additionally, clients are very often compliant out of courtesy and politeness, and they appear to be so in some of the transcripts from *Focusing-Oriented Psychotherapy* (Gendlin, 1996).

Most therapies use rhetoric of emancipation or liberation of human potential. That is, they aim to free persons—from "incongruence," "irrational cognitions," "addictions," "mental illness," "low experiencing level," and so on. Claims for success in psychotherapy depend on being able to say that change for the better is a consequence of the independent variable of psychotherapy. However, non-directive client-centered therapists are leery of accepting treatment effect sizes as the last word on practice. We believe that the harmful effects of therapy are rarely investigated and reported (a notable exception is the work of Binder and Strupp, 1997).

Iatrogenic effects of medical treatments, which are regularly discussed at Mortality and Morbidity conferences among physicians, have no formal counterpart in the world of psychotherapy. Therapy, even at its most non-directive, can have, and has been observed to have, negative effects on clients. Sometimes this is the result of momentary loss of

discipline by the therapist; sometimes it results from a client's having misunderstood a therapist's communication. But we know that these inadvertent mistakes can have far-reaching consequences. How much more damaging to a person's sense of positive self-regard are practices *designed* to change clients—either their lack of congruence, or their “stuck” ways of processing or some other deficiency? The kinds and extent of harm that therapists can cause, outside of violations of professional standards and ethics, is a largely unexplored area of research.

The centrality of the right to refuse

Clients' right to refuse psychological and psychiatric treatment is crucial in any democratic society that promises basic human rights. Various authors have made reference to the significance of the human person's “power to refuse” (Weil, 1987). Only our perception of the humanity of another can halt the trajectory of our intended action, and allow, as Simone Weil puts it, “that interval of hesitation, wherein lies all our consideration for our brothers in humanity.” Winch's (1989) reading of Weil explains her position:

To recognize the existence of another human being is to acknowledge a certain sort of obstacle to some projected actions; that is to say, it is to acknowledge that there are some things one *must* do, and some things one *cannot* do in dealings with the other which hence constitute a limit to the ways in which we can pursue our projects. Our recognition of these necessities is internally related to our grasp of the kind of beings we are confronted with. (p. 107)

Notions of “voice,” self-determination, and personal autonomy imply that a fundamental aspect of humanness is the exercise of will—of the capacity and right, at bottom, to say “yes” and “no.” Personal assent and dissent are expressions of freedom. Only persons who can *refuse* can freely *assent* to enter into a relationship of equals. Unequal as a therapeutic relationship may be in the structural sense, if a person seeks the relationship voluntarily and maintains at each moment of this relationship the “power to refuse,” there is, to some degree, a meeting of two sovereign persons (Proctor, 2002; Schmid, 2001). A broken person is one who has given up the attempt to give or withhold consent and who perceives that others perceive her as no longer constituting an obstacle to their plans or actions.

What does the “power to refuse” mean in the context of a client-centered therapy relationship? This power, first, must mean the freedom to withhold expression, either partially or entirely. Clients cannot be interrogated, probed, encouraged, or induced to speak. The act of speaking, making contact with the other, should be understood as a free expression, a call from one Person to an Other, not as linguistic production or symbolizing process (at least within the moment of the encounter.) The only appropriate response to the other's voice is the act of response issuing from my authentic self. I think that this kind of call and response is what Buber refers to as an “I – Thou” relation, a concept which Rogers valued and referred to over many years.

One of the first problems the client-centered therapist faces, however, is that many clients come into the relationship from social and familial contexts that have long denied

their personal authority. Compliance with familial norms and obedience to authority figures has been deeply inculcated in most of us. We cannot naively assume that clients know therapy is a “free” situation. Many clients believe that they should not *ask* questions and that conversely, they should *answer* any questions put to them by the counselor or “doctor.” They need help and feel vulnerable, which exacerbates the situational pressures against their grasping their own power to refuse. That power exists in the abstract, perhaps, and functions as a constraint for the non-directive therapist, but is not yet a reality to be grasped and lived by many clients. The fundamental aim of the client-centered therapist is to offer oneself in an entirely personal way, without professional facade. We believe that the practice of empathic understanding increases clients’ personal power. This assumption has been borne out in practice with clients over many years (Zimring, 2001).

We claim that our aim is to be of help, but we cannot know in advance what “help” will mean to any given person. It must always remain an open-ended question in our work: “Am I helping you?” Clients are the experts on what is or is not “help,” and more radically, when they cease to want “help” in any form. When this point is reached, the therapy relation must be redefined or ended, because its essential structure is that of a therapist who is present in the situation to *give* “help” and a client who is present in the situation to *receive* it.

Is it a contradiction to hold this consistent non-directive position to the exclusion of techniques and pedagogy? Is not this rigidity, a kind of tyranny of non-directiveness imposed on clients? Cain (2002) asserts that the emphasis on the therapist attitudes leads to a “one approach fits all” stance to therapy. He states:

The same basic attitudinal qualities in the therapist or teacher are viewed as necessary and sufficient for all clients (students) regardless of individual differences in the person, even enormous ones. Not surprisingly, there is generally fairly little variation in the ways person-centered practitioners interact with their clients. (Cain, 2002, p. 367)

Cain does not see that because client-centered therapists are committed to the non-directive realization of the attitudes with no attempt to create effects in their clients, they provide an environment for the emergence of a unique therapeutic relationship with each new client and with each client in successive sessions. To the contrary of his claim, there is a *great deal of variation* in the ways client-centered practitioners interact with their clients—as much variation as there are persons.

A staunch commitment on the part of the therapist to non-directivity implies moment-to-moment attunement to a client as a whole person. In the mature form of client-centered therapy (meaning practice in which the therapist is freely himself or herself in the situation), many possible implementations of the attitudes may emerge. We are not behaving according to a method or formula, nor are we responding with any systematic intent, except to empathically understand whatever clients intend to express. It is inconceivable that a client-centered therapist would say to a depressed client who wanted to stop coming to therapy, “I don’t think that would be wise. I think you need to stay a little longer until you are feeling less depressed and can think more clearly about the decision.” This kind of paternalism is a contradiction to non-directiveness. It undermines

and ultimately abrogates clients' power to refuse. We want to honor clients' frames of reference, because it is right and because it is what we want for ourselves.

Conclusion

Directiveness matters. Even with the best intentions, it promotes influence over clients. Process-directive therapists have clear aims for how clients can change emotional schemes and “stuck” contents. They have appropriated the core conditions and empathic responding without recognizing that by their orchestration and direction, they have altered the character of these conditions. They have replaced Rogers' empathic way of being with methods of doing, and they have replaced trust in clients with a “new paradigm”—trust in the expert.

References

- Binder, J. L. & Strupp, H. H. (1997). ‘Negative process’: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical psychology: Science and practice*, 4 (2), pp.121- 139.
- Bozarth, J. (1998). *Person-centered therapy: A revolutionary paradigm*. Ross-on-Wye, UK: PCCS Books.
- Bozarth, J. (2002). The evolution of Carl Rogers as a therapist. In D. Cain (Ed.), *Classics in the Person-centered Approach*, Ross-on-Wye, UK: PCCS Books, pp. 43 – 47.
- Brodley, B. T. (1988). Does early-in-therapy experiencing level predict outcome? Unpublished paper presented at the second annual meeting of the Association for the Development of the Person-centered Approach in New York City, May 1988.
- Brodley, B. T. (1990). Client-centered and experiential: Two different therapies. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties*. Leuven, Belgium: Leuven University Press, pp. 87 – 107.
- Brodley, B. T. (1997). The non-directive attitude in client-centered therapy. *The Person-centered Journal*, 4, (1), 18 – 30.
- Brodley, B. T. (2002). Client-centered: An expressive therapy. *The Person-centered Journal*, 9, (1), 59 – 70.
- Cain, D. (2002). The paradox of nondirectiveness in the person-centered approach. In D. Cain (Ed.), *Classics in the person-centered approach*. Ross-on-Wye, UK: PCCS Books, 365 – 370.
- Gendlin, E.T. (1964). A theory of personality change. In Worchel, P. & Byrne, D. (Eds.). *Personality Change*. New York: Wiley.
- Gendlin, E. T. (1974). Client-centered and experiential psychotherapy. In Eds. D. Wexler, and L. Rice (Eds.), *Innovations in Client-centered therapy*. New York: John Wiley & Sons, 211 – 246.
- Gendlin, E. T. (1996). *Focusing-oriented psychotherapy*. New York: Guilford.
- Goldstein, K. (1939). *The organism*. Boston: Beacon Press.
- Goldstein, K. (1940) *Human nature in the light of psychopathology*. Cambridge: Harvard University Press.
- Grant, B. (1985). The moral nature of psychotherapy. *Counseling and Values*, 29 (2).

- Grant, B. (1990). Principled and instrumental non-directiveness in person-centered and client-centered therapy. *Person-centered Review*, 5 (1).
- Greenberg, L., & Paivio, S. (1997). *Working with emotions in psychotherapy*. New York: The Guilford Press.
- Hendricks, M. (1986). Experiencing level as a therapeutic variable. *Person-centered Review*, 1 (2), 141- 162.
- Polanyi, M. (1958). *Personal knowledge: Towards a post-critical philosophy*. Chicago: University of Chicago Press.
- Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: Ethics, politics, and practice*. Ross-on-Wye, UK: PCCS Books.
- Prouty, G. (1999). Carl Rogers and experiential therapies: A dissonance? *Person-centred Practice*, 7 (1), 4 –11.
- Raskin, N. (1988). Responses to person-centered vs. client-centered? *Renaissance*, 5 (3&4), 2-3.
- Rogers, C. R. (1942) *Counseling and psychotherapy*. Boston: Houghton Mifflin.
- Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston: Houghton Mifflin.
- Schmid, P. (2000). Prospects on further developments in the person-centered approach. In J. Marques-Teixeira and S. Antunes (Eds.), *Client-centered and experiential psychotherapy, Linda a Velha*, Portugal: Vale & Vale, pp. 11 – 31.
- Schmid, P. (2001). Comprehension: The art of not knowing. Dialogical and ethical perspectives on empathy as dialogue in personal and person-centered relationships. In S. Haugh & T. Merry (Eds.), *Empathy*, Ross-on-Wye, UK: PCCS Books, pp.53 – 71.
- Weil, S. (1987). Are we struggling to justice? Trans. Marina Barabas, *Philosophical investigations* 53, (January 1987), 1 – 10 (translation of ‘Luttons-nous pour la justice?’ in *Ecrits de Londres*, 45 – 57).
- Winch, P. (1989). *Simone Weil: The just balance*. New York: Cambridge University Press.
- Zimring, F. (1997). Looking at empathy and focusing in a new way: What we do determines what we get. In *Proceedings of the 4th International Conference on Client-Centered and Experiential Therapy* Lisbon, Portugal: Sociedade de Portuguesa de Psicoterapie Centrada na Pessoa e Abordagem Centrada na Pessoa.
- Zimring, F. (2001). Empathic understanding grows the person. In S. Haugh & T. Merry (Eds.), *Empathy*. Ross-on-Wye, UK: PCCS Books, pp. 86 – 98.