A Client-Centered Psychotherapy Practice[i]

Barbara Temaner Brodley

Illinois School of Professional Psychology at Argosy University
Chicago

My intent here is to provide a brief description of the principal features of my client-centered psychotherapy practice. My practice has evolved from my attempt to embody Rogers' ideas about helping relationships in my work with clients over many years. In preparing this paper I hope some other client-centered therapists will be stimulated to describe their own practices so we can have discussion of the similarities and differences among us.

I subscribe to Rogers' first principle - the actualizing tendency inherent in persons (1980a). I view this tendency as the sole and original motivating principle in human beings which brings about growth, differentiation, development, self-maintenance and change. I also subscribe to Rogers' theory of the necessary and sufficient conditions of therapeutic personality change (1957). These conditions are the attitudes of congruence, unconditional positive regard and empathic understanding of the client's internal frame of reference. I view the actualizing tendency and these attitudinal conditions to be applicable to all therapeutic relationships with all individuals.

I also subscribe to a set of values which are implicit or explicit in Rogers' theoretical writings [1]: (1) Human nature is intrinsically constructive. (2) Human nature is intrinsically social. (3) Self-regard is a basic human need which, along with autonomy and individual sensitivity, is to be protected in helping relationships. (4) Persons are motivated to perceive realistically and to pursue the truth of situations. (5) Perceptions are a major determinant of personal experience and behavior. Thus, to understand a person one must attempt to understand him/her empathically, from the perspective of his/her own perceptions. (6) The individual person is the basic unit and the one related to in situations intended to foster growth and change. Not groups, not family groups, not organizations, etc. (7) The concept of the "whole

[i]Editor's Note: This paper was prepared for the Third International Forum on the Person-Centered Approach meeting in La Jolla, California from August 7-14, 1987.

person" is part of the helper's experience of the person in therapy. (8) In helping relationships, the pursuit of control or authority over other persons is abdicated. Instead, there is a commitment to share power and control. (9) A belief that persons are realizing themselves and protecting themselves as best they can under the internal and external circumstances that exist at the time. (10) In helping relationships, the helper is committed to honesty in relation to him/herself. This honesty is a major means for the helper to maintain and enhance his mental and emotional health and the health of his relationships.

Through the years I have thought about my work with clients a great deal. I made many observations of the effects I was having on my clients. And I tried to determine whether or not I was working consistently with Rogers' theory. I have adjusted my behavior with clients when it seemed inconsistent with the theory and did not seem helpful to my clients. The following discussion is about the main features of the practice that has evolved.

The Conception of Goals and Implementations

The principle of an actualizing tendency, the specific theory of the attitudinal conditions for therapeutic change, and the value/assumptions which I have described are active elements in the therapist's mind and feelings throughout the therapy relationship. These elements also function before the specific therapy relationship begins. They influence the conscious, a priori choices that I make about goals and about how they are implemented. Out of my reading of Rogers and out of my experience as therapist I subscribe to the following conceptions which are general and prior to relating to any client.

My a priori goal for my client is to help my client realize his/her own goals. These client goals may be clear from the beginning of the work and may or may not change during the course of our work, or they may be unclear and tentative and evolve and change during the course of our work. Usually these goals involve gaining relief from psychological pain or suffering, making changes in the client's self in ways the client perceives as growthful or more healthful, and making changes in the client's life situations such that the situations are more conducive to the well being and effectiveness of the client and close others. But I never have specific goals in mind for my client not at the

beginning nor at any point in the therapy. I work only from my awareness of the client's goals, although I do not adopt even those.

I do have specific goals for myself that are prior to and apply to all my therapy relationships. I try to provide the interpersonal conditions which I believe are - if experienced by the client - productive of growth, change, health and relief from pain. My immediate and constant goal for myself in the relation with my client is the living and experiencing of the three attitudinal conditions and the living of my respect for the client and his rights in the relationship. I want to be congruent, to be accepting in an unconditional way and to empathically understand my client - all of these to the greatest extent possible, and I want to express these attitudes so the client has the opportunity to experience me as having these attitudes in the relationship. Conscious and unconscious disciplines are involved in realizing these personal goals in relationships with clients. Wanting does not, alone, make it so.

What are my a priori conceptions about the *implementation* of the ideas and attitudes that have been mentioned? In answering this question I feel I must address my view of what it is that is therapeutic in my client-centered therapy work with clients - that is, what the mechanisms of change involve.

The Mechanisms of Change

I believe the change processes in the client are the result, directly, of the attitudinal conditions being provided and experienced to some significant degree by the client. The mechanism is the process of adoption, by the client, of the attitudinal conditions in him/herself and toward him/herself. The process of adoption of the attitudinal conditions by the client into self frees and enhances the capabilities and energies of the client. This process brings out the client's wisdom about himself and arouses potentialities to be realized more fully in his/ her life.

The explorations, understandings, insights, the releases of tensions, the actions the client takes in new ways outside the therapy session and other things that happen in the process of therapy - are the concrete ways the particular client lives in and experiences the attitudinal conditions. These ways are not only stimulated by the therapy relationship, but also are new experiences because they are

occurring in the context of the therapist's attitudinal conditions. The interaction between the client's behavior/experience while in therapy and the client's sense of the attitudinal conditions *as context* results, I think, in the gradual absorption and adoption of the attitudinal conditions.

Rogers (1984) expressed this idea of the mechanisms of change. He said that he thought the mechanisms basically involve the client taking on the three therapeutic attitudinal conditions in himself and toward himself and others. Looking at the therapy process and its effects over the years, this seems the truest accounting to me. The processes are immensely variable and the ways people feel progress and change appear to be so different from person to person. What stands out as the most constant observable in all that variability is the way in which clients become more congruent, more accepting towards self and others, and more empathic towards themselves and others.

An important implication of this view of what it is that works to make therapeutic change happen is that it does not matter from the perspective of creating change what the client talks about or expresses or whether or not the client talks about his most serious or significant issues. Whatever level of risk or emotional engagement the client offers is that client's concrete participation in the relationship. It is the basis, then, of the client's interaction with me, with the attitudinal conditions being a salient expression of myself in the relationship. The therapist does not need to be concerned or worry about whether or not the client is "getting at" what "he should get at". Thus the therapist is truly freed of concerns that can result in directiveness and judgmentalness.

Returning to the idea of implementations - what, given my above stated conception of the mechanisms of therapeutic change, are my a priori ideas about implementation of the attitudinal conditions and attitude of respect for the client?

The truest theoretical answer is that the implementation of the therapeutic attitudes depends upon the state of the client, the nature of the client's participation, and upon the capabilities and imagination of the therapist. In other words, there is no standard or inevitable way in which the therapeutic conditions are lived out or expressed in client-centered therapy.

There is, however, a very likely way of implementing the attitudes in my work with individual clients, given the type of client I am likely to meet and given my capabilities and imagination.

The clients I see, and have seen for the most part of the past twenty six out of thirty two years of doing therapy, are clients who are able and willing to discuss or explore their concerns, problems and personal experiences. With these clients the form of interaction which seems to me most natural and effective as an implementation of the therapeutic conditions is the empathic understanding response process (Temaner, 1977). This is the way of working illustrated by Carl Rogers in his films, demonstrations and typescripts of therapy sessions.[2]

I shall discuss this major form of interaction in the next section, but now wish to state a perspective which I would like the reader to keep in mind as he/she reads along. First, the way of working I am discussing and describing as my own is not being put forward as the only way of working that can be based on Carl Rogers' theory. This presentation is intended to communicate the main features of *my* way of working from Rogers' theory. It may coincide with the way other client-centered therapists work or it may not, although I expect there would be at least overlap between my way and the way of others. Second, I am discussing only individual therapy in this paper. Third, my use of the empathic understanding response process as my major form of implementation with clients who feel a need for help and who are able to talk about their concerns is not meant to imply that this is the only or inevitable implementation of Rogers' theory with such clients.

The Empathic Understanding Response Process

The empathic understanding response process is the salient form of my therapeutic work with clients. Within this form there is a unique and spontaneous interaction between myself and each client. There are always great differences in the qualities of interactive expressiveness and the use of language between me and each client. Each relationship is unique and different in many ways. But the form within which all this uniqueness and differences take place does have certain regular or consistent characteristics:

1. The therapist is experiencing congruence and unconditional positive regard in relation to the client and experiencing the intention to empathically understand the client.
2. The client is communicating to the therapist talking and expressing about him/herself.
3. The therapist is able to experience specific empathic understandings of the particular client's internal frame of reference.
4. The therapist attempts, from time to time, to check the correctness of his/her felt understanding by making empathic understanding responses, or by making responses that summarize what the client seems to have been expressing, or by asking questions for clarification of the client's meanings.
5. The client feels understood, feels accepted-(not judged or evaluated) by the therapist, and experiences the therapist as genuine in their relation.
6. The client develops feelings of freedom and personal power in the relation with the therapist, has feelings of safety from punishment by the therapist, has feelings of being stimulated to explore and think more deeply about his/her concerns, and has feelings of affection and attachment to the therapist.
7. The client continues to talk and express and explore his/her problems more deeply and expansively; and the client feels he/she is making progress.
8. As the interaction continues with the qualities described above, the therapist has a strengthened and higher level experience of the therapeutic attitudes and builds a richer empathic experience of the client in his/her own experience/memory.

The empathic understanding response process can be superficially identified or recognized by the salience of empathic understanding responses, summaries and questions for the purpose of clarification by the therapist. And by the appearance of a self-exploratory process in the client's communication.[3] Although it may be difficult to identify with certainty, the empathic understanding response process is only genuine and full of the potency of the genuine process if the therapist is experiencing the therapeutic attitudes at a high level and the client is feeling them.

Other Forms and Kinds of Interaction

The empathic understanding response process has always been the salient and, to me, the most natural and effective implementation of the therapeutic attitudinal conditions. In my early years of doing therapy - perhaps at least the first ten years from 1955 to 1965 - I felt uneasy and uncertain about other forms of interaction with my clients. Although I engaged in these other forms on some occasions.

I answered questions, for example. But I would be very aware of the possible misunderstandings that could come from my answers, and aware of the judgments or values that could be read in my answers. I feared I was violating the atmosphere of acceptance and understanding that I was committed to providing by bringing in, even implicitly and with care not to do so, my ideas and values in answering questions.

I was committed to the therapeutic relation as a genuine person-to-person relation. I did not want to play a role or act as if I had a right, because of my expertise or status, to assert authority over my clients. It seemed, therefore, that I had no alternative, when asked, but to answer any question as honestly and well as I could. But then I felt I might be destroying the feelings of safety and of freedom I was, otherwise, stimulating in my client. It was a dilemma I suffered with for a long time.

The discussion that follows, about other forms, comes out of having resolved my earlier feelings of dilemma. I accepted that there could be other forms of interaction with my clients than empathic understanding response process. And I discovered I could still be faithful to client-centered theory and values.

There are, with many of my clients, sequences of interaction which are interspersed within the empathic understanding response process. They are breaks or intermissions in that process. These breaks may be very brief and/or rare with some clients, while with others one or more of these forms of interaction may be extensive and/or frequent. The forms to which I am referring, here, are: (1) Therapist-presenting in response to client questions. (2) Accommodations requested by clients. (3) Initiation by the therapist of thoughts, feelings or reactions about the client, including (a) responses out of persistent feelings and (b) spontaneous responses.

So far, I have described the empathic understanding response process and indicated that there are these other forms of interaction I engage in when doing therapy. Now, in order to communicate to the reader the nature of these other forms I need to elucidate an *attitude* that is present in my work which, I believe, is inherent in Rogers' theory. This attitude informs and influences any implementation of the theory of therapy. This attitude is called the "nondirective attitude".[4]

The idea of client-centered therapy as "nondirective" has become problematical because some teachers and therapists have made rigid and incorrect interpretations of the element of nondirectiveness in client-centered therapy.[5] I must risk some of the bad associations which now adhere to the idea of "nondirective" because I believe the nondirective attitude is a significant element in Rogers' theory of therapy and in my own work.

The Nondirective Attitude

Nondirective refers to an *attitude* toward the client and toward therapeutic work with the client. It is an attitude that develops in the therapist from whole-hearted and consistent subscription to the first principle of client-centered theory. The belief in the actualizing tendency and the valuing of and respect for the client stimulate feelings of sensitivity towards the client's directions, interests and self-maintaining processes. But the nondirective attitude does not refer to an avoidance of giving specific direction such as support, information, guidance, answers, etc., to clients. Rather, the nondirective attitude is an inner experience of freedom from *assuming* what might be good or helpful for clients. It also includes being free of impulses to express one's helping instinct in the form of giving direction or interpretations. This involves an acceptance of the outsider's ignorance and helplessness in finding and effecting solutions to other people's problems. It involves, I think, a quality of humility.

The nondirective attitude also includes being free to provide responses to clients - responses which may appear directive - when they are requested, without feeling a need to justify them by assuming they are helpful. Another way of stating this is to say that the therapist can feel the freedom to be cooperative with the client's experiments that emerge out of what the client thinks or feels might be helpful to him. This is a willingness to share some of the client's risks.

The avoidance of directive responses can be a form of directive attitude in the context of a client's request for such responses. Brink (1987) states this position as follows:

> When nondirectiveness is rigidly adhered to as the supreme principle to direct therapist behavior, a doubly reductionistic system results. The complexity of the client is reduced to fit a pre-conceived model that derives from a reduction of Rogers' rich threefold approach to providing a growthful climate for his client. By clinging to the idea of equality-expressed-nondirectively, the therapist creates a reality of unbridgeable inequality by remaining the wielder of a powerful technique, clearly the expert in control of the therapeutic relationship, a professional role rather than a helping person (pp 30-31).

The nondirective *attitude* expresses the strong emphasis Rogers' theory places on respect for the client as a distinct and unique person who has natural requirements and rights for maintaining his self-regard, self-regulation, self-direction and a feeling of well-being or enhancement in situations.

It is likely to be damaging and disempowering for one to submit (without very good and special reasons) to a situation in which another person is allowed to assume superior knowledge and power over one's own experiences or their meaning. I have come to this conclusion from listening to clients and friends describe their relations with former therapists, physicians, teachers, employers and some parents. Self-regard and confidence in self are vulnerable attributes. The destructive things done by people in these roles of authority are often done out of good intentions. People, including otherwise mature adults, often submit to the authority of these roles. The authority of the therapist, like that of the physician, is especially dangerous because the people served are usually in a personally vulnerable condition. Most therapists, even the avowed humanistic ones, believe they should figure out what is wrong with their client, figure out what strategy (treatment plan) is appropriate for the client, and then carry out the strategy with definite goals in mind for the client. In other words, a directive attitude is rampant in the field of psychotherapy, except, as

far as I can tell, among therapists who try to function consciously from the person-centered perspective or from Rogers' client-centered theory.

Many therapists will refuse to answer client's questions, or not even rearrange appointment times, on the grounds that they will be catering to the client's dependence, or succumbing to the client's manipulations, or being complicit in the client's avoidance of significant issues. These interpretations convey to the client that he/she should stay in line, not ask questions, and not initiate things out of their perceived self interest. They have the impact of both control and disapproval.

These interpretations, if swallowed by the client in the context of the client's having asked a question or having attempted to initiate something, are very likely to undermine the client's appropriate feelings of authority and sense of confidence.

Refusing to answer a question on the basis that it would not be good for the client to be given an answer by the therapist is an example of the therapist's using the professional role and status in the therapy set-up to exercise control and authority over the client. It is a refusal to cooperate with the client on the basis of the client's sense of what might be helpful or needed by him at that time. This is paternalism - acting on one's own ideas of what might be good for another person without their enlightened consent or against their wishes.

The paternalism of "I, the therapist, know what is best for you, better than you do" is an expression of directive attitude and reflects little faith in the client's capacity to discover his own directions and solutions. The nondirective attitude, in contrast, expresses the feeling that the client is the best expert about himself.[6]

The nondirective attitude also involves the feeling, in the therapist, that he/she has the responsibility while in the therapy relation to be mindful of and protective towards the client's autonomy, self-direction and self-regulation by keeping an eye and a restraint on his/her power in the therapy situation.

The nondirective attitude is a pervasive attitude which influences the expression of the therapeutic attitudinal conditions when they are implemented by empathic understanding response process and when they are implemented by the several other forms of interaction which I shall now discuss.

Responding to Clients' Questions

I respond directly and acceptingly to questions asked by my clients. In ordinary person-to-person relations, we normally respond to questions according to our inclination or ability to answer. Even if our personal inclination is not to give the information or not to exert the effort to give an answer, our normal courteousness requires acknowledgment of the question and an explanation or an excuse for not answering what was requested.

This ordinary approach to questions is based on the assumption of the freedom of both persons (to ask questions and to answer or to refuse to answer) and the assumption of equality between the persons with concomitant respectfulness towards each other (by answering or accounting for not answering).

I think these same values apply in the therapy relation. Whether or not the response to the client's question turns out to be significant for the client, or helpful in any way, treating questions respectfully (and thereby treating the client respectfully) contributes to the quality of the relationship experienced by the client. It reaffirms the therapist's genuineness as a person and reaffirms the therapist's abstention from power over the client.

There are some things I do to make the question/answer interaction clear between me and my client and which give this form of interaction a more fluid connection to the empathic understanding response process.

First, I engage in empathic process to clarify the question. I want to address the question that is truly being asked and sometimes this requires considerable back and forth clarification between me and my client. Second, while answering the question I try to explicate my methodology and my sources of information in arriving at an answer. I want to share my means to the answer and demystify my answering. Third, after I have presented my answer I check with the client "Did this answer really respond to what you wanted to hear about?" and, also "Do you have any reactions to the answer I've given?". Fourth, the client's responses to these questions are treated as any client communication about himself - with the therapeutic attitudes implemented by empathic process.

These procedures seem to help integrate the question/answer situation with the empathic understanding response process even

though it is a distinct break in empathic process because the therapist is speaking from his/her own frame of reference.

As a consequence of this open, respectful and non-paternalistic attitude toward clients' questions, some sessions or portions of a session may consist of the therapist's responsive expressions and the subsequent interactions between client and therapist that relate to the therapist's responses.

Over time, employing the approach to questions as described, I have been surprised, but gratified, to learn from my clients that my way of answering questions has not been experienced as directive nor experienced as a break in my attitudes of acceptance and understanding. It seems that my commitment to, and the consistency of my feeling the therapeutic attitudes, and my feeling nondirective, together with the circumstances of my client asking questions of me, have the effect of transforming what might otherwise be experienced as directive into meanings for that client that are close to or identical with the meanings experienced when we are engaged in empathic process. In other words, I have the impression from my clients that they experience me as consistently congruent, accepting and empathically understanding when I am literally giving information, explaining something, or disclosing something about myself, or, even, giving an opinion concerning them from my own frame of reference!

Accommodations by the Therapist

Another expression of the nondirective attitude which results in a form of interaction other than empathic understanding response process is my response to requests for special procedures or accommodations. I am open to making accommodations. I do not require that the client nor I have assurance that the accommodation will be helpful or, even, not harmful. My attitude is experimental and I try to communicate that that is my attitude toward whatever my client has requested, if I agree to participate in it.

Kinds of accommodation which have been asked of me include the following: modifications in the length and frequency of sessions, the arrangements in the therapy room, the use of telephone for sessions, the use of the therapist as a monitor or director, the use of the therapist as an advocate, the use of the therapist as a trainer or instructor, the use of the therapist as a resource, etc.

The break in empathic understanding response process that occurs in responding to requests for accommodation may be minimal or extensive. If the break is a matter of discussing, for example, a modification in the usual pattern of sessions, the break is likely to be minimal. If the accommodation, however, is for a significant modification in the actions I am being asked to employ in interactions with the client (e.g., a request to monitor the client for distractive themes in his conversation and to directively help the client to maintain a more focused presentation) the process of discussing this modification and the process of employing it - both - may make an extensive break in pure empathic understanding response process.

Over the years that I have been accommodating to my clients' requests I have become aware of some criteria that function implicitly to influence whether or not I cooperate. These are: (1) whether or not I have the skills, capabilities, knowledge or expertise at an adequate level, (2) whether or not I have a genuine interest in functioning as the client requests, (3) whether or not my personal and professional circumstances realistically permit the accommodation, (4) that I experience clarity of understanding of the client's request, what it is and what it is for, (5) that I have an open feeling, or if my feeling is reserved, that I am able to be clear about that and share it with the client, (6) in general, that I feel able to be honest with the client in disclosing my feelings about the accommodation or my experience of it as we go along, (7) an experimental attitude about the accommodation, that it can be evaluated and changed if it does not suit either of us.

These criteria have become more conscious and explicit as I react to a client's request for accommodation, over the years. But whether explicit or implicit they constitute a demand on the therapist to know him/herself and his/her feelings well and to experience a high level of congruence in the relationship.

But it is important, I feel, to point out that among my criteria is one about judgment as to whether or not the accommodation is likely to be helpful. If asked for my opinion on this point by my client, I give an opinion if I have one. Of course, if the accommodation was, in my judgment, an unethical or destructive one I would discuss this with the client and probably would not cooperate with it. This point is important because, I believe, it reflects the sharing of control of the therapy with the client and the nondirective attitude.

Therapist Initiation of Thoughts, Feelings and Reactions

The implementation of client-centered values and the therapeutic attitudinal conditions through creating and maintaining empathic understanding response process has, I believe, developmental effects on the therapist. The experience, over a long time, of empathically understanding clients cultivates in the therapist a discipline wherein the therapist loses the temptation to deviate from the process.

The over time effect on the therapist of empathically understanding seems to involve a reinforcement and development of the therapeutic attitudes, respect for the client and the nondirective attitude. I have observed in myself a diminished temptation to be drawn away from empathic attention to my client by ruminations or by speculations about my client. It seems to me that the discipline and practice of empathic understanding gradually influences the consciousness and the desires of the therapist as he/she engages in the process with client after client.

I do not think about, speculate about, worry about or diagnose my clients when I am with them nor during the intervals between sessions. A client may come to my mind, occasionally, outside of a session. And I may have a moment of wondering how someone is doing, given the problem or task they are facing. I also have affectionate images of clients, sometimes, between sessions, but these are momentary. There are occasional exceptions to what I am saying, but they are rare. In general, my relation to clients is almost entirely within the empathic connection, during sessions with them. And my focus is on understanding them empathically during the time we are together.

There are, however, occasions when I *initiate* responses from my own frame of reference and express them to my client. These responses, obviously, are not empathic understanding responses. They are from my own frame of reference, and they are not responses to requests or questions from my client. They occur in or emerge out of the context of empathic understanding response process.

There are two types of non-empathic responses initiated by me that I have become aware of - responses occurring out of persistent feelings and spontaneous responses.

Responses Out of Persistent Feelings

This category of therapist-initiated responses that issue from the therapist's internal frame of reference are occasioned by the therapist's experiencing a persistent feeling that is not empathic or not acceptant in the context of empathic understanding response process. The persistent feeling may be beginning to evoke a feeling of incongruence in the relationship from the therapist's point of view.

An example of such a persistent feeling is a situation wherein the therapist is aware of having feelings of irritation or annoyance towards the client, and these same feelings arise occasionally in some sessions. The therapist attends more deeply to these feelings and notices that they arise in reaction to what seems an innuendo in the client's remarks. The therapist realizes he/she has interpreted this perception of an innuendo as covert criticism of the therapist, and this is why he/she is annoyed. But the stimulus is ambiguous, when looked at anew. The client may be feeling and expressing some criticality towards the therapist, or something else may be bringing about the appearance of an innuendo.

I go about responding to such a persistent feeling situation in the following way: (1) I ask the client for permission to discuss something I have been feeling. (2) I explain the feelings in a straightforward but tentative manner. I try to be clear and honest about the feelings, and tentative about my interpretation that the client is expressing critical feelings towards me. (3) I ask the client what he or she feels about my reactions and interpretation. (4) All of the client's responses to my question become the focus of my empathic attention and I orient myself to respond empathically. It depends upon the client's reactions to my disclosures as to what further discussion might ensue.

This category of therapist-initiated responses based on persistent feelings is discussed by Rogers (1980b). The view that the client-centered therapist should feel free to speak out from his/ her own frame of reference in response to persistent feelings is endorsed by Rogers' acknowledgment that this is his own practice. He presents this kind of responding as a corrective for incongruence of the therapist in the relationship when he is experiencing non-empathic or non-acceptant feelings in relation to one's client.

In addition to being a corrective for incongruence, the addressing of persistent feelings is a corrective for not understanding empathically. If the therapist is experiencing the therapeutic attitudes at a high level and in that context, if these other feelings do emerge with some persistence, then there must be something being expressed which is not yet empathically understood.[7]

An important reason, to my mind, for addressing a persistent feeling that is outside the parameters of the empathic is *to further understand*. I am not making any assumption about its being therapeutic for the client for this problematic experience of the therapist to be explored. It is probably good for the therapist (whether or not it is good for the client) because addressing the persistent feeling is likely to result in clarification for the therapist of the client's feelings and bring the therapist back to the empathic domain in respect to the stimulus situation. By addressing his feelings, the therapist has created the possibility of understanding his own experience in the situation. He/she re-establishes congruence and frees him/herself to return to an undisturbed empathic understanding response interaction.

Spontaneous Responses

This category of therapist-initiated responses are made spontaneously (i.e., without being thought through beforehand) about the client, to the client, in the context of the empathic process and they have not been elicited, as the former category is, by persistent feelings. I think this category may be what Rogers refers to in his article (1986), that presents his interview with "Jan", and which he calls "intuitive" responses.[8]

Spontaneous responses seem to happen only in the context of an extended relation with a client. In my case they don't come up in the first or early interviews with a client. They happen when the empathic understanding process has been underway and developing in me a very strong and rich sense of the client's feelings, attitudes, ideas and circumstances.

It is also usually the case, when spontaneous responses occur, that my client has previously asked me some questions, or asked for some accommodation. And I have experienced the client as able to understand me very well and accurately. That is, the client has been able to take in my responses to him - specifically the ones that came

from my frame of reference - as I intended them. Misunderstandings have not developed in my relation with the client.

Distractions from empathic process do not happen very often in my work. When they do I am likely to give the thoughts, feelings or reactions consideration after the session to assess whether or not they may have relevance to my empathic understandings or my relationship with my client. I usually put them aside, in the session, and re-attend to my client. But this category of "spontaneous responses" refers to distractions to which I give utterance, and I do so without much thought beforehand. These responses include evaluative reactions (e.g., "that's awful"), interpretations, integrations of material previously discussed with present material, providing examples from my own imagination or from my memory of material from the client, self-disclosures that serve as illustrations of the client's point, self-disclosures that contrast to the client's point, etc.[9]

It seems to me that when I have uttered responses that I am categorizing as "spontaneous responses" they have had particular qualities, to me, subjectively. These qualities are as follows. First, the thoughts, feelings or reactions are relevant to the client's agenda of purposes that have been communicated previously or, more likely, the particular session. But they may not be relevant to what the client is immediately expressing. They usually do not, but they may, change the subject. They are not empathic understanding responses, summaries or questions for clarification. They are a distinct break in the empathic process with its close empathic following of the client.

Second, the thoughts, feelings or reactions that become spontaneous responses have, for me, a quality of importance for the client. This is a feeling that the client would be very interested in what has occurred to me. This does not mean I am right about my impressions. I am describing the subjective character of the spontaneous responses as I sometimes experience them as I am voicing them. These responses at least some of them- seem at the time like insights for the client. Third, they usually have the character of spontaneous reactions, not ideas I have been thinking about nor ruminations that I have been experiencing during the session. They seem to come to me all of a sudden in the context of listening and engaging empathically.

Immediately before voicing a spontaneous response I usually tell my client that I have some thought or reaction that might be of

interest to him or her, and I ask permission to voice it. And, after I have expressed whatever it is, I usually ask if I have been clear, ask if there is any question about it, and I ask what the client's reaction to it is at the time. These procedures surrounding a spontaneous response allow the client to orient to taking in something that is not empathic understanding and allow me to find out some of the effects on the client of what I have expressed.

Most of the reactions I have had from clients with whom I have voiced spontaneous responses are supportive about these responses. Clients often express a feeling of appreciation that I have shared my reaction. They seem to feel a reassurance from it that I am open with them.

As far as the usefulness of the spontaneous responses is concerned, that is variable. For the most part, the client either accepts my thought, feeling or reaction as directly helpful in contributing to their self understanding or as directly empathic in attitude, even if it is not immediately relevant to what they had just been expressing. Another response, in respect to usefulness, from my clients has been a kind of differentiating reaction. In these instances the client denied the truth or accuracy of what I expressed about them, but it seemed to stimulate a more exact or truthful self-realization. So, for the most part, my impression with my clients, when I have voiced spontaneous responses, is that they are utilized constructively. And they also seem to contribute to my clients' sense of my realness and my desire to be helpful.

I am being explicit and candid in writing about my "spontaneous responses", but I feel uncomfortable in writing about this kind of response because I fear I might be misunderstood.

I do not want to sound like I am justifying this form of response in client-centered therapy. I don't want to come across as if I am recommending this form of response. I do not mean to recommend it to anyone, even to myself. Whether it will hold up in my practice, or not I don't know. I have been experimenting by allowing it to happen for some time. Spontaneous responses, it should be understood, are not deliberate, not intended. I do not think they can be intended. Intention would make a different phenomenon.

I am uncomfortable about writing of these spontaneous responses because they basically go against my conservative version of client-centeredness in which I place a great emphasis and

dependence upon the empathic understanding response process as implementation of the therapeutic attitudes. But, over a long time, in my work, they have gradually emerged and I have given myself license for them. So much so that I feel they must be listed with the forms of response that occur in my therapy. This is so even though they are still not frequent and occur not at all with some clients.

Summary

I hope I have given the reader a sufficiently clear idea of the major features of my client-centered work with individual clients. And I hope I have given some idea of my theoretical rationales for these features. I regret I have not provided examples, other than the few, of the other-than-empathic-process forms of interaction which occur in my practice. I simply have not had time to go over tapes to select examples. This is something I plan to do for a later version of this paper.

The main features of my practice which have been discussed are: (1) My conception of a priori goals and implementations. (2) Emphasis on and salience of the empathic understanding response process as implementation of the therapeutic theory - with clients who feel they have problems and feel they need help and who are able and willing to discuss themselves. (3) Forms of implementation of the therapeutic attitudes which constitute a break in empathic understanding response process. The role of the nondirective attitude is discussed. The forms which are other-than-empathic process are - therapist presenting in response to client questions, therapist accommodations, and therapist-initiated responses of two types - responses to persistent feelings and spontaneous responses. (4) Some conditions for the occurrence of these forms and some procedures surrounding the forms are also discussed.

Endnotes

1. These values are discussed in a paper by J. Bozarth and B.T. Brodley (1986). The tenth value, however, was suggested by Alberto Zucconi.

2. See Appendix A for an illustration of empathic understanding response process in an excerpt from a film of Carl Rogers in a therapy session with "Miss Mun".

3. Empathic responses and client self-exploration are not a sure sign of the presence of empathic understanding response process. It is possible to use empathic responses as a technique and for the client to respond with self-exploration without the basic therapeutic attitudes being present in the therapist. This technique type of process may be helpful, as are many other things therapists may do with their clients.

4. Raskin (1947) discusses the nondirective attitude as well as in his paper, "The development of nondirective therapy" (1948).

5. This is discussed eloquently by Brink (1987).

6. The belief that the client is the best expert about himself is not a naive and blind optimism that denies people can make terrible mistakes about themselves. It is an optimistic view, but based on many observations that - under conditions of freedom, safety and understanding people take responsibility, perceive clearly, utilize their information well, and learn from experience, with the result that they make better and better choices. The individual person has, potentially, the most total access to self that is possible, through consciousness and processes of thought and feeling. This amalgam under therapeutic conditions tends to result in an amazing and effective expertise.

7. In the context of empathic understanding, responses of annoyance or disturbance in relation to clients simply do not occur, even if the material coming from the client would, from my own frame of reference, stimulate annoyance or disturbance. Therefore, the persistent feelings that are annoyance or disturbance signal, to me, a lapse in, or incomplete, empathic understanding.

8. I am not referring to these responses as "intuitive" because the word implies that the responses have validity or correctness for the client and because the term implies knowledge not grasped through perception and reasoning..

9. See Appendix B for an example of a spontaneous response from a fortieth session with a young woman who suffers from a chronic physical illness.

Appendix A[ii]

C29: I was thinking the other night, I was feeling very blue about the way I felt, and I thought, well... maybe, I wish I had my mother here in the way that she was, because she used to be... sort of reassuring when I was ill and she would do little things, and make some special dish, like custard or something. It was sort of reassuring sort of to have her around. (T: Mhm) And, of course, I know that she isn't able to be that way any longer. I don't know what it all means, but for a minute I thought I really miss her. I sort of need a mother at this point and yet that's sort of impossible...

T29: But even though it's factually impossible, the feeling was... 'Gee, I miss her, I wish she was here to take care of me and look after me'. (C: Mhm)... (19 sec. pause)

C30: And yet at the same time I felt, well - a little later, so - I thought that... maybe that wasn't what I needed, maybe it was a more adult... sort of... companionship or something in some way, rather than a mother. But I needed something or somebody...

[ii] In the course of many years, Barbara transcribed and supervised others in transcribing Rogers' therapy and demonstration sessions. The transcript work culminated in a joint effort with Germain Lietaer resulting in a journal article (Lietaer & Brodley, 2003) and an informal email publication (Brodley & Lietaer, 2006). We have replaced the therapy segment by Rogers that Barbara originally included here with the more polished 2006 version.

T30: You really didn't feel sure in yourself whether... what you wanted was someone to really... give you close mothering... or whether you wanted some more... grown up kind of relationship...

C31: And then, in another sense, I thought, well... maybe it's just something I have to go through alone.

T31: Maybe it's just hopeless to wish that I could really be in a relationship with anybody... Maybe I *have* to be alone.

C32: The thing that sort of has thrown me this week is that... well, I feel better about the physical condition I talked of last week, and I sort of made friends with my doctor which makes me feel a little better, as though we're not going to be quietly fighting without saying anything. And I think that I have more confidence in my medicine. I read an article about this and it said it's very hard to diagnose, so I don't hold that against him. But he feels he has to be sure, sort of... (words lost) giving me X rays and I'm frightened because I kind of feel that they're trying to be sure it isn't cancer. That really frightens me terribly (T: Mhm), and.... I think it's when I let that... thought come to me, maybe it is and what if it is and... that's when I felt so dreadfully alone.

T32: HmHm... You feel if it's really something like that... then you just feel *so* alone. (8 sec. pause)

C33: And it's really a frightening kind of loneliness because I don't know who could be with you... and it seems rather. (7 sec. pause)

T33: Is this what you're saying? 'Could... could anyone be with you in... in fear, or in a loneliness like that'? (Client weeps) (30 sec. pause) Just really cuts so deep. (C shakes her head) (13 sec. pause)

C34: I don't know what it would feel like if there were somebody around that I... could feel sort of... as though I did have someone to lean on, in a sense... I don't know whether it would make me

feel better or not. I was trying to think, well, it's just something that you have to grow within yourself... Just sort of stand... even just the thought of it, I mean, it'll be two weeks, I suppose, before they know. Would it help to have somebody else around, or is it just something you just have to... really be intensely alone in? And that's the... well, I just felt that way this week, so dreadfully, dreadfully, all by myself sort of thing. (T: Mhm)...

T34: Just a feeling as though you're so terribly alone... in the universe, almost, and whether... (C: Uh-hum) whether it even - whether anyone could help - whether it would help if you did have someone to lean on or not, you don't know. (15 sec. pause)

C35: I guess probably basically, that'd be a part of it you would have to do alone. I mean, you, just couldn't take anybody else along in some of the feelings; and yet, it would be sort of a comfort, I guess, not to be alone.

T35: It surely would be nice if you could take someone with you a good deal of the way into your... feelings of aloneness and fear. (14 sec. pause)

C36: I guess I just have. (20 sec. pause)

T36: Maybe that's what you're feeling right this minute. (19 sec. pause)

C37: And I think it is a comfort. (Long pause - 1 min. 27 sec.) And I guess the feeling I have now is, well, I'm probably looking on the very blackest part of it. And maybe there's no real need for that... I mean I... It may just take time to reassure me. (5 sec. pause) And then this will all be sort of unimportant (mhm), although it's something I shan't forget, I'm sure (Laughs) (T: mhm)...

[Brodley & Lietaer, 2006, vol. 10, Miss Mun, pp. 65-67]

Appendix B[iii]

C: I do this...I think about that kind of stuff all the time... And I sit there and go..."why do you do this?", "why do you even think about this stuff?"

T: That you have such intricate motives...(C: yeah)...and you wonder why you think of yourself that way. (C: nodding)... Uh um.

C: It's a vicious cycle.

T: ...I have a guess...would you be interested...? (C: nods) This is a speculation as to how this kind of suspicion of yourself developed...the question is... why do you have the suspicion of yourself? (C: Right) What I am speculating is...that here you had an illness that was out of your control...That's a fact...And you had pain ...and different discomforts...and it was dangerous for you. (C: nods) And what is a natural human feeling under these circumstances?...It's wanting to have control... And so, you started scrutinizing yourself and the events and almost wishing that...

C: I see what you're saying.

T: To feel like you could have some control instead of just being this person who is a victim.

C: I understand...That makes sense.

T: ...Do you think that might...(C: Yeah, because it's like...) be the origin, how it got generated?...You weren't trying to do anything to yourself, you were (C: Right) trying to get control and so reading them...

[iii] From a fortieth session with a young woman who suffers from a chronic physical illness.

C: So, underneath it all, the bottom line would be...yeah... I'm attributing powers to myself because at least that would mean I had control over it. (T: Uh-um)...I can see what you mean...(T: Uh um) Yeah...that sounds more like me, like the me I really know and trust. (pause)...I'm sitting here thinking about all this stuff I just realized. (T: Yeah) ...(C: laughs)...I was feeling that before...for awhile I've been feeling ...growth. But I still have that vulnerability in me...But deep down I know I'm going to be OK. There's something deep down I just...

T: Something's taken hold, some greater trust in yourself? (C: Uh-um) Another level? (C: Yeah).