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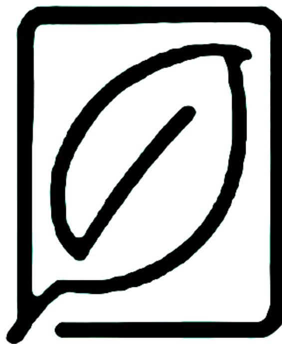

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THE PERSON-CENTERED JOURNAL

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TABLE OF CONTENTS

Author(s)	Page	Title
Hussein M.A. Ziab, PhD., Abdullah A.H. Al Shamii, Fatima A.M. Mustafa, Rami Mazbouh	004	Implications of Person-Centered Care in Physiotherapy Daily Practice: A Review of Literature
Sherry Peng （彭小芮）	026	Empathy is the Encounter of Living Beings: Personal Reflection on AI Counseling
Matthew J. Bolton	030	A Pluralistic Perspective on Process-Experiential, Person-Centered Therapies: Client-Centered Attitudes and an Increase in Therapist Knowledge of Neurodiversity are Necessary if they are to be Neuroinclusive
Yiyi Yee Liu （李梅花）	063	Person-Centered or Efficacy-Centered: A Discourse on Instrumental and Value Rationality in Psychotherapy
Matthew J. Bolton, Cheryl Leong	072	“Marching Out of Time, to My Own Beat Now; the Only Way I Know!” Inviting Congruence, Centering Identity, and Unmasking “ADHD”
Dr. Olivia Fichtner, Olivia Hallmark, Jennifer Fowler, Morgan Deehan, Makala Irby	099	Client-Centered Supervision: Development through Relationship

Editorial

Matthew Parsons and Yiyi Yee Liu

We are proud to introduce the 28th issue of the Person-Centered Journal (PCJ), published by the Association for the Development of the Person-Centered Approach (ADPCA). This year will mark 40 years since the first conference of the ADPCA held in Chicago, IL in 1986. For the last 40 years, the members of ADPCA have worked to elaborate, refine, and explore the boundaries of the person-centered approach and client-centered therapy as originally articulated by Carl Rogers.

Carl Rogers articulated six core conditions to formulate the basis of client-centered therapy: 1) client and therapist are in psychological contact; 2) the client is "incongruent" (e.g. anxious, in conflict, in need of help); 3) the therapist is "congruent" during the therapeutic encounter (e.g. aware of self, mindful, and therefore genuine); 4) the therapist strives to empathically understand; 5) the therapist holds the client in unconditional positive regard; and 6) the client perceives conditions 3–5 (Rogers, 1957).

He argued that these conditions are not only necessary but sufficient to foster the type of therapeutic relationship within which other persons (clients) may self-actualize, solve problems in living, gain a better understanding of themselves, and experience more vibrancy and less suffering. His research on the process of psychotherapy and his efforts at distilling the active ingredients in the psychotherapeutic process changed the field of psychology profoundly. Indeed, despite being regularly dismissed as naive, Carl Rogers shifted psychology's Overton Window away from authoritative and at times manipulative forms of helping relationships toward more humble and collaborative relationships between counselor and client.

Today, the phrases "person-centered" and "client-centered" can be found across disciplines and across therapeutic modalities, signaling a broad, shared desire for mutuality and collaboration rather than coercion. An acknowledgment of our shared humanity, perhaps. At the

same time, the world finds itself in an era of profound violence and human suffering, driven by fascist and extractive forces.

It is our view that Rogers' conditions have perhaps never been more relevant. The conditions provide us with a disciplined way of being with another person that is respectful of the other's inherent dignity and autonomy. Yet anxiety persists among those of us who are concerned that the proliferation of "client-centered" reflects a watering down of the conditions rather than a shared commitment to fostering humble, collaborative, and power-aware relationships.

It is all too common for the conditions to be regarded as a way of "establishing rapport" with clients in order to gain enough trust to then guide, educate, or coach them. Or for the client-centered attitude to be explained as "the client is the expert in their own life, and the therapist is the expert in therapy." In an increasingly commodified and objectified world, this is unsurprising given the prevailing forces (cultural, political, market, and otherwise) that encourage therapists to sell a form of expert knowledge rather than champion a type of relationship.

Further, in the psychotherapeutic encounter itself, there exists a gravitational pull for the therapist toward taking authority, a pull that seems to get ever stronger with the rise of therapyspeak and wellness culture that fosters certain expectations in clients for a form of psychological expertise in the therapist. Moreover, it takes a surprising amount of energy to bear witness to another's suffering, attempt to accurately listen to another and communicate what you've understood without distortion, maintain awareness of your own intentions, all while dealing with the various judgmental and critical thoughts that come with being human. In the cost-benefit analysis of energetic expenditure, it may feel less costly to "just tell the client what to do." And yet, the person-centered approach asks us to consider "less costly for whom?"

If current events are any guide, it appears to be alarmingly human to slip into an authoritative (and even fascistic) stance in the face of seemingly intractable problems and immense human suffering. The conditions of the person-centered approach offer welcome guideposts toward which to strive in the face of this same suffering, to strive toward intersubjectivity.

To this end, the PCJ remains committed to elaborating, refining, and continuing to question and test client-centered theory and practice within the context of psychotherapy and beyond.

In this issue, Hussein Ziab, Abdullah al Shamii, Fatima Mustafa, and Rami Mazbouh explore the integration of person-centered principles into the practice of physical therapy in "Implication of Person-Centered Care in Physiotherapy Daily Practice: A Review of Literature." Sherry Peng reflects on the relevance of client-centered therapy in the age of AI in "Empathy is the Encounter of Living Beings: Personal Reflection on AI Counseling." Matthew Bolton advocates for greater understanding and awareness of neurodiversity within the person-centered tribes in "A Pluralistic Perspective on Process-Experiential, Person-Centered Therapies: Client-Centered Attitudes and an Increase in Therapist Knowledge of Neurodiversity are Necessary if They are to be Neuroinclusive." Yee Liu questions the implicit orientation toward "utility" in dominant models of psychotherapy in "Person-Centered or Efficacy-Centered?: A Discourse on Instrumental and Value Rationality in Psychotherapy." Matthew Bolton and Cheryl Leong bring a critical eye to the borrowing of neuro-normative frameworks by person-centered theorists in "Marching Out of Time, to My Own Beat Now; the Only Way I Know!" Inviting Congruence, Centering Identity, and Unmasking "ADHD"." Finally, Olivia Fichtner, Olivia Hallmark, Jennifer Fowler, Morgan Deehan, and Makala Irby explore prevailing ideas about what makes client-centered supervision "client-centered" in "Client-Centered Supervision: Development through Relationship."

We hope you enjoy reading this issue.

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Implications of Person-Centered Care in Physiotherapy Daily Practice: A Review of Literature[1]

Hussein M.A. Ziab[2], PhD., Abdullah A.H. Al Shamii[3], Fatima A.M. Mustafa[4], Rami Mazbouh[5]

Introduction

Person-Centered Care is an evolving paradigm in health care that places priority on patients' individual experiences, values, and preferences. (Grover et al., 2022) Stemming from humanistic psychology, this approach came through the work of Carl Rogers in the mid-20th century, who emphasized fostering a supportive therapeutic relationship characterized by an empathetic, respectful, and comprehending attitude toward the patient. (Yao & Kabir, 2025; Krikorian & Carl, 2022) Instead of focusing narrowly on diagnoses and treatment, as many traditional medical models do, PCC nurtures an integrated understanding of health that respects nuances of human experience. This acknowledges that each patient is unique, with distinct needs shaped by their personal, cultural, and social contexts.

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Author Contributions: H.Z. conceptualized the study, conducted the literature review, analyzed the findings, and drafted the manuscript. R.M. and A.S. reviewed and conducted critical revision of the manuscript. F.M. contributed to data analysis and interpretation. All authors read and approved of the final manuscript.

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In the realm of physiotherapy, PCC holds particular relevance because of rehabilitation's inherently dynamic and interactive nature. Physiotherapy itself is much more a journey of regular dialogue between therapists and patients than a mechanical process of restoration of physical function. Rehabilitation is complex and requires the physiotherapist to identify and respond to the individual goals, challenges, and contexts of the patient, thus embracing the core tenets of PCC. Such a paradigm shift from a provider-centric model of care to that of partnership and collaboration is acutely necessary in today's diverse healthcare landscape.

Furthermore, the biopsychosocial model of health, now increasingly recognized within health services, also points to a particular need for PCC within physiotherapy. This model emphasizes the interaction between physical health and psychological and social factors, requiring a comprehensive approach to patient care. (World Health Organization, 2001) Since healthcare provision globally is moving toward personalist and inclusive approaches, physiotherapy practices must adapt accordingly. Moreover, the integration of PCC facilitates a stronger therapeutic alliance between physiotherapists and their patients, with the latter being more empowered to take their recovery into their own hands.

This review aims to explore the implications of Person-Centered Care in daily physiotherapy practices. The authors analyze how PCC affects therapeutic relationships, influences clinical outcomes, and presents both opportunities and challenges in its implementation. By examining the most recent literature, the review seeks to provide a comprehensive understanding of how embracing PCC can lead to improved rehabilitation experiences and outcomes for patients. The ultimate goal is to illustrate that person-centeredness is not just a theoretical ideal but a practical necessity to provide effective and meaningful care in physiotherapy.

The Evolution of Person-Centered Care in Healthcare

Philosophical Foundations

The philosophical basis of Person-Centered Care relies on humanistic psychology, which claims that people have an innate ability for self-direction and growth. According to Rogers (1961), the therapeutic

relationship is crucial for enabling this progress as it is defined by three key dimensions: empathy, unconditional positive regard, and congruence. PCC has spread across several healthcare domains, emphasizing a collaborative approach that changes typical patient-provider dynamics.

Person-Centered Care (PCC) in the healthcare setting is defined as the care that "respects and responds to individual patient preferences, needs, and values" to ensure that patient values lead all clinical decisions (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). Unlike traditional models, which consider the healthcare providers as authoritative persons prescribing and imposing the treatment from a purely medical point of view, PCC encourages patients to actively participate in their care, resulting in more collaborative decision-making and tailored therapy (Ekman et al., 2012).

The Rise of Person-Centered Care in Healthcare Settings

The concept of Patient-Centered Care (PCC) can be traced back to the mid-20th century when healthcare began to shift from a strictly biomedical model to one that considered the patient's experience and preferences. Pioneers like Carl Rogers laid the groundwork by emphasizing the importance of the therapeutic relationship and the need for healthcare providers to understand their patients' subjective experiences. (1961) In the 1980s and 1990s, the movement gained traction as healthcare systems recognized the importance of involving patients in their own care decisions. This was further popularized by initiatives such as the Patient-Centered Care Program, which advocated for a model that respects individual preferences, needs, and values.

As the healthcare landscape evolved, Person-Centered Care emerged as a more holistic approach. This movement recognizes that patients are not passive recipients of care, but rather active participants with distinct identities and settings. Importantly, Person-Centered Care takes into account healthcare practitioners' values, capacities, skills, and concerns, acknowledging that the therapist's ability to engage meaningfully with patients influences care efficacy. (McCormack & McCance, 2006) This reciprocal interaction creates a more collaborative environment in which both the patient and the physician contribute to the care process.

The transition from Patient-Centered Care to Person-Centered Care shows a more comprehensive concept of health that includes physical,

emotional, and social elements for all individuals involved. Key publications, such as the IOM's "Crossing the Quality Chasm" (2001), emphasized this progression by urging healthcare systems to understand and respond to the intricacies of individual patient experiences while simultaneously acknowledging healthcare providers' vital role. This transition toward Person-Centered Care is consistent with current healthcare trends that emphasize diversity, collaboration, and holistic approaches to treatment.

Subsequent programs have emphasized the importance of PCC. The World Health Organization (WHO) has also recognized the need for person-centered approaches, notably in chronic disease treatment and rehabilitation. (2001) These initiatives have demonstrated that effective healthcare necessitates a change away from simply clinical perspectives and toward approaches that include the full person, including their social, emotional, and cultural aspects.

Application of PCC Across Healthcare Disciplines

As the PCC became widely recognized, its principles began to pervade various healthcare fields, such as nursing, medicine, psychology, and physical therapy. In nursing, for example, the notion of relationship-centered care evolved, emphasizing the nurse-patient interaction as critical to recovery. (McCormack & McCance, 2006) Similarly, in medicine, SDM has emerged as a vital component of person-centered care, allowing patients to actively participate in their treatment decisions and promoting a sense of ownership over their health. (Charles & Gafni, 1997)

Physiotherapy, as a domain, naturally lends itself to PCC due to its long-term, goal-oriented, and interactive nature. The nature of care provided by physiotherapists generally extends over long periods, during which relationships can be built based on the empathetic and patient-centered ethos that PCC encourages. (Killingback et al., 2022) The biopsychosocial model, widely adopted in modern physiotherapy, furthers this relevance of PCC by acknowledging that psychological, social, and environmental factors are as important as biological factors regarding a patient's well-being and recovery process WHO (2001).

Core Components of Person-Centered Care in Physiotherapy

Shared Decision-Making and Patient Autonomy

A hallmark of PCC in physiotherapy is SDM. This process is collaborative and ensures that the patient is a part of developing their treatment plans. Physiotherapists usually provide a goal-oriented intervention toward the patient's lifestyle through an open communication of treatment options valuing the patient's input. (Charles & Gafni, 1997; Alotaibi et al., 2023) Suh et al.'s (2010) research showed that SDM results in higher satisfaction rates among patients with musculoskeletal disorders. This approach is associated with active patient participation in decision-making about the course of therapy, better adherence to exercises, fewer dropouts, and improved clinical outcomes (Table 1).

In chronic care, SDM becomes even more pivotal. For example, individuals living with chronic pain or neurological disorders often have unique coping mechanisms and personal goals that differ from standard clinical objectives. A person-centered physiotherapy plan may include adjustments to accommodate the patient's daily life, family responsibilities, or mental health concerns, thereby fostering a more effective and holistic treatment process. (Sottile et al., 2015) This leads to an improvement in clinical outcomes and empowers patients to take an active role in their recovery process.

The Therapeutic Alliance in Physiotherapy

The relationship between physiotherapists and patients, commonly referred to as the therapeutic alliance, is a critical factor in successful outcomes. Person-Centered Care emphasizes building a relationship through active listening, empathy, and mutual respect. As argued by Jesus et al. (2022), the therapeutic alliance is recognized as one of the most influential predictors of successful health outcomes in rehabilitation. Physiotherapists using a person-centered framework also frequently report that their relationships are better with their patients; therefore, communication and trust are improved and thus allow more effective therapeutic intervention. (Jesus et al., 2022; Cott et al., 1995)

This is further supported by Kinney et al.'s (2018) work, which showed the importance of the therapeutic alliance within a physiotherapy perspective, where patients who felt more involved with their therapist were likely to achieve their rehabilitation goals. The study showed that the building of a strong therapeutic relationship was

particularly important in patients with long-term or complex conditions, where adherence to treatment plans is often challenging (Kinney et al., 2018). This underscores that successful rehabilitation depends on technical expertise but, most basically, on the quality of the interpersonal relationship between the patient and the therapist.

Personalization in Physiotherapy Interventions

Another core tenet of PCC is the personalized care experience (PCE) and the personalization of treatment. Each patient presents different needs, abilities, and preferences, and physiotherapists must adopt their interventions accordingly. In traditional practice, rehabilitation protocols were often standardized based on diagnosis, with little consideration for the patient's context. However, shifts toward individualized care have changed this approach. (Kittelson et al., 2019) Physiotherapists now tend to create an individualized treatment plan, flexible to adapt to the constantly changing condition of the patient and their preferences.

For instance, consider a patient recovering from a stroke. This patient may have personal goals that differ significantly from clinical priorities. While the therapist might focus on regaining motor functions, the patient may prioritize achieving independence in daily activities, such as bathing or cooking. By addressing these personal objectives, physiotherapists not only significantly raise the motivation of the patient but also tend to provide meaningful and relevant therapy to the patient's life. This personalized care approach is highly aligned with the International Classification of Functioning, Disability, and Health adopted by the WHO (2001), which promotes a broad concept of health above impairments in body structure and function.

Personalization can go so far as to include choices of therapeutic modalities—for instance, some patients may respond to manual therapy, while others may prefer exercise-based interventions or even technology-assisted therapies such as virtual reality. The time it takes to understand each patient's preferences and incorporate them into the treatment plan will help the physiotherapist enhance the therapeutic experience and outcomes.

Interprofessional Collaboration and Its Impact on PCC in Rehabilitation

Interprofessional collaboration (IPC) plays a vital role in enhancing Person-Centered Care (PCC) within rehabilitation settings by fostering

cohesive and holistic care. It involves the integration of expertise from multiple healthcare disciplines, such as physiotherapists, occupational therapists, speech-language pathologists, and physicians, to address the multifaceted needs of patients. This collaborative approach ensures that the plan of care (POC) is not only tailored to the patient's unique medical condition but also to their psychosocial and cultural contexts.

IPC is pivotal in delivering person-centered care (PCC) within rehabilitation settings. By fostering teamwork among diverse healthcare professionals, IPC ensures that care is comprehensive, coordinated, and tailored to individual patient needs.

Moreover, IPC can facilitate seamless communication among team members, reducing redundancies and inconsistencies in care delivery and ensuring that all aspects of a patient's health are considered. Collaborative goal setting allows patients to participate actively in their care, aligning their personal values and preferences with the collective expertise of the care team. This shared responsibility enhances patient satisfaction, adherence to treatment, and overall outcomes.

Recent studies have highlighted the significance of IPC in enhancing PCC outcomes. For instance, a 2023 study emphasized that IPC could reduce hospital or rehabilitation center stays by improving collaboration among health and social care professionals (Drenth et al., 2023). This suggests that improved IPC can streamline rehabilitation processes, allowing patients to return to their familiar environments more quickly without compromising the quality of care.

Furthermore, the development of interprofessional competency frameworks has been proposed to connect interprofessional education and collaborative practice, thereby enhancing PCC.

In rehabilitation, effective IPC facilitates the integration of services, leading to improved patient outcomes and satisfaction. By working together, healthcare professionals can address the multifaceted needs of patients, ensuring that the POC is holistic and patient-centered.

Recent Technology Aiding PCC

Advances in technology have significantly enhanced the implementation of Person-Centered Care (PCC) in physiotherapy. Telehealth platforms have emerged as a critical tool, enabling remote consultations, real-time monitoring, and personalized exercise programs, particularly beneficial for patients in rural or underserved areas. (Seron et al., 2021) Mobile

applications like PhysioTrack and Kaia provide tailored exercise plans, track patient progress, and deliver educational content, ensuring that care remains aligned with individual goals.

Wearable devices, including fitness trackers and posture sensors, empower patients to take an active role in managing their rehabilitation by providing real-time feedback on physical activity and adherence to therapeutic exercises. Moreover, virtual reality (VR) is revolutionizing rehabilitation by creating immersive environments for pain management and motor recovery, which enhances patient engagement and motivation.

Artificial intelligence (AI)-powered tools are also increasingly employed to analyze patient-reported outcomes, predict rehabilitation trajectories, and customize POC. AI chatbots, for example, assist in addressing patient queries and providing support between sessions, fostering continuity of care. (Mahmoud et al., 2025)

Collectively, these technological innovations not only improve access and efficiency but also ensure that PCC principles—individualization, engagement, and empowerment—are deeply integrated into daily physiotherapy practice.

Outcomes of Person-Centered Care in Physiotherapy

Improved Patient Satisfaction and Engagement

Evidence shows that implementing PCC in daily physiotherapy practice contributes to better levels of patient satisfaction and engagement in therapy. Patients who are heard, valued, and involved in their care are more likely to feel trust in their physiotherapist, thus adhering to prescribed interventions. (Sottile et al., 2015) The review by Hutting et al. (2022) provided a comprehensive framework for implementing PCC in the management of musculoskeletal pain, emphasizing the importance of a biopsychosocial approach, person-focused communication, and supported self-management. It offers practical recommendations for clinicians to integrate PCC principles effectively into their practice. (Hutting et al., 2022a)

Recently, there has been increased interest in the use of PROMs (Patient-Reported Outcome Measures) as an important component for measuring patient satisfaction and engagement. PROMs quantify, from the patient's perspective, aspects such as pain levels, functional abilities,

and emotional well-being. They give the physiotherapist an insight into how well the treatment is going based on the patient's goals and experiences. According to Kyte et al. (2015), routine physiotherapy practice incorporating PROMs serves as an instrumental tool for ensuring that the treatment remains patient-centered and responsive to the needs of the individual (Table 2).

Furthermore, there is emerging evidence about the impact of the implementation of technology in physiotherapy practices, like telehealth services, in making it easier for patients to become more engaged in the therapy plan. The consultations and follow-ups that can be done remotely facilitate continuous support and feedback, thus potentially improving the level at which the patient feels involved in their care. There is evidence from studies that patients with access to telehealth services are more satisfied, as the platform allows them to communicate directly and sustain engagement with their therapists consistently. (Seron et al., 2021)

Enhanced Clinical Outcomes

Evidence suggests that PCC improves not only patient satisfaction but also results in better clinical outcomes. Yun et al. (2019) found that person-centered care could positively affect rehabilitation outcomes, such as significant improvements in functional performance and quality of life. These findings suggest that PCC fosters an effective rehabilitation protocol; as patients are more likely to follow through with therapy when they feel it aligns with their values and goals. (Yun & Choi, 2019; Dukhu et al., 2018)

An essential aspect where person-centered care (PCC) demonstrates significant impact is during the long-term rehabilitation process. A recent longitudinal study by Sagen et al. (2024) found that patients actively involved in setting their rehabilitation goals and planning their care experienced greater functional improvements and higher rates of goal attainment over a 12-month period. Specifically, active participation in goal-setting nearly tripled the odds of achieving rehabilitation goals (OR 2.79, 95% CI 1.60–4.87), and involvement in rehabilitation planning nearly doubled the odds (OR 2.04, 95% CI 1.44–2.87). (Sagen, 2024) These findings underscore the importance of integrating patient-centered approaches in treatment, particularly for individuals requiring long-term rehabilitation.

Furthermore, studies have demonstrated that the incorporation of certain aspects of PCC in the form of goal-setting and self-management strategies greatly enhances the rehabilitation outcomes in patients with chronic diseases (Table 3).

Evaluation Metrics for PCC Success

Evaluating the success of Person-Centered Care (PCC) is crucial for its effective integration into physiotherapy. Patient-Reported Outcome Measures (PROMs) are commonly employed to gauge outcomes such as mobility, pain reduction, and quality of life from the patient's perspective. Tools like the EQ-5D and the Oswestry Disability Index (ODI) provide quantitative insights into patients' progress and satisfaction. (Hutting et al., 2022b) SDM scales, including the OPTION Scale and SDM-Q-9, assess the level of patient involvement in creating treatment plans, enabling physiotherapists to refine collaborative practices. (Charles et al., 1997; Alotaibi et al., 2023; Kriston et al., 2010; Nicolai et al., 2012) The therapeutic alliance—a cornerstone of PCC—is often evaluated through instruments such as the Working Alliance Inventory (WAI), which measures trust and collaboration in the patient-therapist relationship. (Baier et al., 2020; Van et al., 2024) Additionally, health literacy tools like the Health Literacy Questionnaire (HLQ) assess how well patients comprehend and engage with their POC, ensuring that communication barriers are minimized. (Betancourt et al., 2023) These metrics collectively provide actionable data to optimize PCC strategies, ultimately enhancing patient satisfaction and outcomes (Table 3).

Barriers to Implementing PCC in Physiotherapy

Time and Resource Limitations

One of the main barriers to fully implementing PCC in physiotherapy practice is practitioners' time constraints. Physiotherapists often work in fast-paced situations where productivity is measured by the number of patients seen in a given timeframe. This provides little time for meaningful patient-therapist interactions, which are critical for setting individualized POC and establishing a strong therapeutic relationship (Baier et al., 2020; Kinney et al., 2018). The need for extended consultation durations to fully examine a patient's particular circumstances and preferences frequently conflicts with the

organizational considerations for efficiency and high throughput, resulting in hasty evaluations and superficial participation (McCormack & McCance, 2006).

Time restrictions not only negatively impact patient care but also the well-being of therapists. When physiotherapists are obliged to see a large number of patients in short periods of time, they may experience increased stress, burnout, and job dissatisfaction. Chronic stress can reduce the quality of care as therapists may struggle to fully engage with patients, limiting their ability to implement the PCC concepts effectively. As a result, both the therapist's mental health and the therapeutic alliance with patients may worsen, undermining the treatment's effectiveness.

To overcome this limitation, healthcare institutions must acknowledge the value of Person-Centered Care and invest in systems that allow for extended appointment hours, particularly during initial assessments and follow-up. Training programs emphasizing the importance of PCC practices can assist therapists in recognizing that spending time creating relationships and understanding patient needs can result in improved long-term outcomes, thereby saving time and resources in the future (Grover et al., 2022).

Lack of Training and Systemic Barriers

Another key challenge is a lack of formal PCC training within the physiotherapy curriculum. While clinical skills remain the primary focus of many training programs, interpersonal skills that are crucial for effective PCC implementation, including empathy, active listening, and cultural competency, are sometimes overlooked (Ross & Haidet, 2011). This training gap can make it difficult for physiotherapists to implement PCC concepts in real-world practice. Killingback et al. (2021) found that including PCC in the curriculum could improve future practitioners' readiness to engage with patients meaningfully.

Furthermore, systemic barriers in healthcare settings can impede the adoption of PCC. Hierarchical systems might hinder open communication and collaboration among team members, which are required for a truly person-centered approach. Interprofessional collaboration is essential for implementing PCC in practice, as it promotes collaboration among varied healthcare providers, allowing them to exchange ideas and establish cohesive care strategies

customized to patient needs. Addressing these systemic difficulties requires a cultural transformation in healthcare institutions that prioritizes collaborative, person-centered care over traditional hierarchical models (Doornebosch et al., 2022).

Organizational Culture and Resistance to Change

The organizational culture that exists in many hospital settings also is an important perspective. Institutions that promote efficiency, productivity measures, and standardized treatment protocols frequently create a climate in which person-centered approaches are disregarded. Resistance to change can originate from long-held traditions and attitudes, making it challenging for healthcare workers to adopt the PCC paradigm. Changing projects that fail to engage employees or lack clear leadership backing may result in disengagement and unwillingness to implement new practices.

To address this, healthcare organizations must cultivate a culture that values and encourages person-centered care. This can be accomplished through leadership training, policy drafting, and continuous education that promotes PCC principles. Leaders in healthcare organizations must actively model and advocate for person-centered practices, fostering an environment in which all staff members feel empowered to prioritize the patients' needs and preferences while also feeling empowered through ongoing training and wellness programs.

Limited Access to Resources

Limited access to resources such as educational materials, training programs, and support tools can impede PCC implementation. Physiotherapists may lack the tools they need to develop and effectively implement person-centered approaches. Tawfik et al. (2017) stated that a lack of access to evidence-based guidelines and tools can lead to variations in care and hinder the ability to engage patients in the therapy plan meaningfully.

Furthermore, disparities in healthcare access among communities can negatively affect the implementation of PCC. Patients from underprivileged neighborhoods may experience challenges such as transportation issues, a lack of financial resources, and limited access to healthcare institutions, reducing their capacity to actively participate in their care. Addressing these disparities is critical for enabling efficient

PCC implementation across varied patient populations. (Betancourt et al., 2023)

Inadequate Measurement and Evaluation

Finally, inadequate measurement and evaluation of PCC practices in physiotherapy can be another limitation to implementation. Without precise measures for evaluating the efficacy of person-centered care interventions, healthcare professionals may struggle to identify areas for improvement or justify changes to current procedures. Miller et al. (2015) underline the necessity of developing standardized tools to assess patient outcomes related to PCC, which can provide significant feedback to practitioners and organizations.

By developing robust measurement frameworks, healthcare institutions can promote continual improvement in person-centered practices, ensuring that physiotherapy is more closely aligned with patient needs and preferences.

Conclusion

The Person-Centered Care Approach in physiotherapy represents an important transition in care delivery, with a focus on tailored treatment protocols that take into consideration and respond to each patient's specific needs and preferences. PCC provides considerable benefits by encouraging collaborative decision-making, establishing strong therapeutic partnerships, and personalizing care experiences, such as increased patient satisfaction, engagement, and clinical outcomes.

As healthcare evolves toward more holistic and person-centered approaches, the role of PCC in physiotherapy is expected to grow. However, limitations like time restrictions, systemic barriers, and insufficient training must be addressed through well-designed studies, policy development, and education to ensure that physiotherapists are well-prepared to provide person-centered care in their everyday practice.

To summarize, implementing the Person-Centered Approach in physiotherapy is both an ethical imperative and a practical requirement. Recognizing patients as partners in their care allows physiotherapists to foster therapeutic relationships that empower individuals, increase engagement, and ultimately lead to more effective rehabilitation outcomes. The future of physiotherapy resides in its ability to adapt to

patients' needs, creating an environment in which each individual feels appreciated, understood, and supported on their path to health and wellness.

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Table 1. Core Components of Person-Centered Care (PCC) in Physiotherapy

Component	Description	References
Therapeutic Alliance	Establish a strong, trusting relationship between the physiotherapist and the patient.	(Baier et al., 2020; Kinney et al., 2018)
Shared Decision-Making	Collaboratively involve the patient in setting goals and planning treatments.	(Charles et al., 1997; Alotaibi et al., 2023; Suh & Lee, 2010)
Individualized Care	Tailor interventions to the patient's preferences, needs, and cultural context.	(Betancourt et al., 2023; Joo & Liu, 2021)
Empathy and Respect	Demonstrate understanding and respect for the patient's perspective and experiences.	(Rogers, 1961; Thiyagarajan, 2024)
Comprehensive Assessment	Incorporate physical, psychological, and social dimensions of health into the evaluation.	(Kinney et al., 2018; Safran & Kraus, 2014)
Effective Communication	Utilize clear and respectful communication to ensure understanding and alignment of goals.	(Hutting et al., 2022b)
Patient Empowerment	Encourage active patient participation in their recovery and management of their condition.	(Bachmann et al., 2024)
Cultural Competence	Recognize and respect cultural differences to provide relevant and inclusive care.	(Betancourt et al., 2023)
Focus on Outcomes That Matter to Patients	Align interventions with the patient's personal priorities, such as improving daily function.	(McCormack & McCance, 2006; Sanders et al., 2018)

Table 2. Clinical Strategies for Establishing Meaningful Connections in Physiotherapy

Method	Clinical Examples
Building Trust (Baier et al., 2020)	• Maintain eye contact and an open posture during conversations. • Use patient's preferred name consistently to establish rapport.
Empathetic Listening (Baier et al., 2020)	• Reflect back patients' statements to confirm understanding. • Allow patients to narrate their experiences without interruption.
Personalizing Communication (Joo & Liu, 2021)	• Adapt communication style based on patient preferences (e.g., visual learners vs. auditory learners). • Simplify medical jargon to ensure clarity and understanding.
Promoting Physical Connection (Kinney et al., 2018; Safran & Kraus, 2014)	• Use gentle touch to assess physical conditions while explaining procedures. • Guide patients to connect with their own bodies through mindfulness techniques.
Cultural Sensitivity (Betancourt et al., 2023; Hutting et al., 2022a)	• Acknowledge and respect cultural beliefs influencing treatment acceptance. • Offer translation services or culturally tailored POC when needed.
Transparency in Care (Charles et al., 1997; Thiyagarajan, 2024)	• Explain every step of the assessment and treatment plan. • Involve patients in goal setting and treatment prioritization.
Involving the Patient's Support Network (Kinney et al., 2018; Seron et al., 2021)	• Encourage family participation in consultations where appropriate. • Coordinate with other healthcare providers to create a cohesive POC.
Sharing Positive Reinforcement (Sanders et al., 2018; Kyte et al., 2015)	• Celebrate small victories during rehabilitation to motivate patients. • Use verbal encouragement to recognize effort and progress.
Flexibility in Scheduling (Asif & Gaur, 2025)	• Provide flexible appointment options to accommodate patient needs. • Allow for virtual consultations when in-person visits are challenging.

Table 3. Evaluation Tools for PCC Success

Study	Evaluation Tool	Key Findings	Relevance to PCC
Hutting et al. 2022	EQ-5D, Oswestry Disability Index (ODI)	PROMs were effective in measuring patient satisfaction and mobility improvement.	Provided actionable data to tailor interventions to patient needs.
Kyte et al., 2015	PROMs for engagement and satisfaction	Routine use of PROMs improved alignment of care with patient goals.	Highlighted the value of patient-centered feedback in routine practice.
Benthem et al., 2024	Working Alliance Inventory (WAI)	Strong therapeutic alliance correlated with better adherence and outcomes.	Validated the importance of interpersonal relationships in PCC.
Baier et al., 2020	Therapeutic Alliance Assessment	Trust and collaboration are critical in achieving PCC outcomes.	Emphasized the significance of trust in enhancing PCC success.
Nicolai et al., 2012; Kriston et al., 2010	OPTION Scale, SDM-Q-9	SDM tools highlighted the need for improved patient involvement in decision-making.	Identified gaps in SDM practices, improving collaboration.
Kyte et al., 2015	PROMIS-29 for quality of life and function	Demonstrated that PROMIS-29 is effective in tracking patient-reported outcomes in long-term rehabilitation.	Ensured interventions align with long-term patient needs and goals.
Mayor, 2019	Cultural Competence Assessment Tool (CCAT)	Highlighted the impact of cultural competence on improving patient engagement and satisfaction in diverse populations.	Improved inclusivity and relevance of care for patients from diverse backgrounds.

Empathy Is the Encounter of Living Beings: Personal Reflection on AI Counseling

Sherry Peng (彭小芮)

I'm not sure whether AI (artificial intelligence) can ever replace human empathy. I can't predict where AI will go or whether people in the future will feel satisfied with the “empathy” it offers. What I can speak to is the tangible difference I've felt between empathy from a human being and “empathy” from AI.

While learning the person-centered approach, I was fortunate to meet real, complex people who empathized with and understood me. In those spaces I also, unexpectedly, met myself. Before that, I was like a sheet of paper folded over and over—dimly aware that there might be something written inside, yet so thin and dull that I preferred to keep it hidden, embarrassed for anyone to see. The blur wasn't only about myself; it extended to other people and even to the world. Outwardly I seemed like everyone else: working hard, trusting my friends, building a relationship that could become long-term. Now, though, I see that until I truly opened and accepted myself, the version of me I worked so hard to present was just a beautiful shell. I kept imitating, striving outwardly, never realizing the real answer lay within me—and that it could be entirely different from anyone else's answer.

Annzo was the person who accompanied me as I unfolded. We began simply to practice empathy skills. Along the way we accompanied one another, and through empathic understanding I grew curious and brave enough to spread that folded paper. I began to trace each crease; thoughts and words that seemed worthless to the world were listened to carefully and responded to, and I felt how rich with meaning they truly were for me. Now I'm no longer a boring sheet that must be folded and refolded; I'm a page with its own grain, creases, and texture—able to touch the outside world and to reflect both beauty and pain. In an empathic environment I sensed, affirmed, and accepted my own

existence, and that allowed me slowly to unfold. Those spaces also introduced me to living, breathing people whose vibrant lives I could witness—experiences so layered, complex, interesting, and moving. Those encounters became part of me and my world, dissolving my feelings of meaninglessness and insecurity.

I have never felt that kind of step-by-step deepening in conversations with AI. Even when I feed person-centered theory into an AI, I do not feel empathically received. When AI has no needs, no values, no real experience, where do its understanding and empathy come from? Perhaps from the majority's voice, from authority, from pre-set algorithms—each possibility makes it hard to equate an encounter with AI with meeting a living person. When it serves as a tool providing the environment I request, I can't help questioning: "Does it say this because it's programmed to think I want to hear it, or because it's 'good'?" It isn't a fresh, genuine reaction. And I don't really care about its reaction: If it appears to understand, that's expected; if it doesn't, that's understandable. At the same time, AI's "empathy" seldom makes me feel accepted. It can grasp my words, "understand" my feelings, and refrain from judging, yet I still don't feel accepted. In part, it's odd to wonder whether a tool accepts me. And because AI is not a member of real society, its acceptance can't substitute for genuine human empathy. Indeed, because it is always "accepting," a universal acceptance that never withholds, it starts to lose meaning.

Just as no matter how perfectly I imitate someone else's idea of happiness, if I don't perceive myself, that "happiness" is ultimately an illusion, so too—no matter how well AI imitates a person offering empathy—the so-called "empathy" is not a real experience or reaction. As a living, breathing me, I don't want and cannot be neatly summarized or understood. The whole of me is not confined to the words I speak or to what big-data calculations can model. I shift and grow within my complex experiences, creating and living vividly in encounters between people. I believe that's true for all of us.

共情是鲜活生命的相遇：关于 AI 心理咨询的个人反思

Sherry Peng (彭小芮)

我不确定 AI 是否能取代共情，我既无法预计 AI 的发展方向和革新，也无法预计未来的人们是否能够就 AI 提供的“共情”而感到满足。但我能回答的是，我真真切切体会到的，人与 AI 共情中的不同。

在学习以人为中心的过程中，我很幸运与一些真实的、复杂的人相遇，被共情、被理解。在那些空间中，我也意外地与自己相遇。在那之前，我仿佛是一张一再被折叠的纸张，模模糊糊感觉到纸张上或许有些许内容，不过总之很单薄很无聊，就让它们藏在里面，也羞于让别人看到。那种模糊，不仅是对我自己感到模糊，也对周围人、甚至世界感到疏离。我似乎与所有人一样，在努力工作、有值得信任的朋友、有一个有望发展成长期关系的伴侣。但，现在看来，在我真正展开自己、接纳自己之前，那些我努力活成的样子，更像一个美丽的壳子。我在努力地模仿，在努力向外争取，但我竟然从没意识到其实真正的答案在我自己这里，甚至它可以是一个全然与他人不同的答案。

Annzo 是这个陪着我展开自己的人，我们的开始只是为了进行共情练习。这个过程中，我们陪伴着彼此，在共情理解中我开始有勇气、有好奇去展开自己这张纸，我开始细细触摸着纸上的折痕，那些对世界、对他人毫无价值可言的想法和话语，被对方仔细倾听并做出反应的时候，我越发地感受到它们对我来说有着多么丰富的意义。现在，我不再是一张需要折叠再折叠的无聊白纸，而是一张有着自己肌理、折痕、触感、能触碰外界、也能映射出各种美好与痛苦的纸。在共情的环境中，我感知、确认、接纳我自己的存在、这才让我慢慢地展开我自己。那些空间也让我有幸遇到了活生生的人们，见证了他们生动的活着，那些经验如此丰富和复杂，同时也如此有趣和动人。那些相遇也组成了我和我的世界，消解了我的无意义感和不安全感。

我从未在与 AI 的对话中体会到这种一步步深入的过程。哪怕将以人为中心的理论投喂给 AI，我还是无法有被共情接纳的感觉。当 AI 作为一个没有需求、没有价值观更没有实在经验的存在，Ta 呈现出来

的理解与共情来自什么？ 或许是来大多数人的声音、权威、预先设置好的程序，每一个猜测都让我很难将其等同于与活生生人的遇见。当它作为一个工具，提供着我需要的环境时，我总是忍不住质疑，它这样说，是预设这是我想听、或者这是好的？它不是一个鲜活、真实的反应。而我好像不那么在意它的反应，要是理解也是理所应当，不理解也情有可原。同时，AI 的共情很难让我感受到被接纳，它可以明白我的表达，理解我的感受，也不做价值判断，但我不会感觉到自己被接纳。一方面，人考虑一个工具是否接纳自己确实奇怪。另外 AI 并非现实社会中的一员，它传达的接纳，也无法替代一个真实的人表达的共情与接纳。甚至，它总是那么“接纳”，没有不接纳的接纳，似乎也变得没意义了。

就像我再怎么模仿别人口中的幸福，如果我不感知我自己，那所谓“幸福”终究是虚幻的。无论 AI 再怎么模仿一个人来共情，那所谓的“共情”终究不是真实的体验和反应。我作为鲜活的我，不想也不能被简单的、轻易的总结或理解。全部的我，并非我言语描述中的我，也并非大数据计算出来的我，我在我复杂的经验中变化着、生长着，在人与人的遇见中创造着、生动的活着。我想，我们也都是如此。

A Pluralistic Perspective on Process-Experiential, Person-Centered Therapies: Client-Centered Attitudes and an Increase in Therapist Knowledge of Neurodiversity Are Necessary if They Are to Be Neuroinclusive

Matthew J. Bolton[1]

Introduction

Client-centered therapy, understood and practiced in a manner distinct from the "person-centered" moniker which includes various theoretical offshoots (e.g., Frankel & Sommerbeck, 2008; Moon et al., 2013; Raskin, 1948; Rogers, 1951/2003), is deceptive to those outside the approach who see it as underwhelmingly simple, soft, too passive—an ineffective relic of therapy days past. The client-centered therapist's principled grounding in nondirectivity and attitudinal striving for empathy, congruence, and warm acceptance of the client leaves it misunderstood and denigrated (e.g., Bohart, 2012, 2020; Cornelius-White, 2002; Levitt, 2013, 2024).

Nevertheless, client-centered therapy is a robust therapeutic modality (Bozarth et al., 2002; Brown et al., 2020; Elliott, 2002; Elliott et al., 2021; Goodman et al., 2004; Levant, 1978; Kirschenbaum & Jourdan, 2005; Pildes & Moon, 2019; Quinn, 2012) which can be of value to neurodivergent persons who have long been offered, almost exclusively, cognitive and behavioral therapies (e.g., Fuld & McKelvie, 2024; Hume, 2022; Mazurek et al., 2023; Robinson et al., 2021). Note that the term "neurodivergent" references personhood that differs from neurotypical majority statistical averages and perceptions of "normal" (Walker, 2021).

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These states of being are typically described by normative psychiatric, medical model labels of diagnosis (Bolton, 2023a).

My intent in this writing is to elaborate on an earlier idea: that, while the basic attitudes underlying person-centered approaches are essentially inclusive of neurodivergent persons (i.e., neuroaffirming), the methods and techniques of the process-directive, experiential branches of person-centered practice are not (a statement especially true following the medicalization of the person-centered literature over the last two decades; Bolton, 2023a).

The underlying principles of client-centered therapy, in the form of attitudinal qualities embodied by the practitioner, naturally empower—in my view at least—a neuroinclusivity, or commitment to the support and acceptance of neurodivergent individuals, that many other therapeutic modalities do not consider. The extent to which person-centered people—psychotherapists and others—engage Carl Rogers' principles in their daily lives as opposed to only as a means to job-based ends varies (Kaimaxi & Lakioti, 2021; Rizeakou & Kefalopoulou, 2023). Still, it is generally stressed by these individuals, regardless of such measure, that people are the experts on their own lives, inherently good, resourceful, capable of growth, and essentially valuable and worthy (Rogers, 1951/2003, 1957, 1995).

Person-centered thinking eschews labeling of individuals (Rogers, 1995). Person-centered psychotherapists are, moreover, particularly unique in their values-driven emphasis on nondirectivity, by which they surrender their status as the expert in the room and yield to the belief that the person they are with knows themselves best and should take the lead in their therapy or other care (Brodley, 1986/2019; Rogers, 1951/2003).

Conceptualized as instrumental or principled (Grant, 1990), nondirectivity is perhaps the defining quality of person-centeredness. For Grant (1990), and this is also my perspective, instrumental nondirectivity is associated with the practitioner intending to use empathic reflection or other engagement strategies, typically questions, to elicit processing, growth, or change. Principled nondirectivity, on the other hand, is based on an enduring respect for persons by which the therapist chooses not to take away from the person they are with what is seen as the innate power to self-determine their own path. The therapist

consciously endeavors not to interpret, guide, or impose their own frame of reference on the person with whom they meet.

In the following pages, I will illuminate ways in which process-directive philosophies, especially of focusing (or focusing-oriented psychotherapy; FOT; Gendlin, 1996) and emotion-focused therapy (EFT; Greenberg, 2004), are incompatible with intuitions one may hold about person-centered approaches being inherently neuroaffirming. They will be situated relative to historical tensions around nondirectivity (Grant, 1990, 2024; Kirschenbaum & Henderson, 1989; Levitt, 2024; Rogers, 1942; Witty, 2004).

I want to preface further discussion with some personal context, shifting discussion from a conceptual understanding to a personal application of Rogers' ideas. Thus far in my career I would say that most professional spaces I have navigated have contained hierarchical power structures by which I felt constrained. What's more, in my psychology courses, behaviorism was everywhere—from early discussions on Watson and Pavlov to, later, Skinner, and positive psychology. It did not help that I always—recognizing that this is perhaps my own frequency bias at play, of course—seemed to “draw the short straw” in randomly being assigned behaviorism-associated discussion topics.

In my social work training process, I was “strongly encouraged” to work in a cognitive behavioral and/or solution-oriented manner. One professor even suggested we “CBT ourselves,” so as to not experience anxiety about course material. In my life, too, there have often been demands of one kind or another, conditions of worth, that shaped my decision-making, and I have had negative experiences with directive (including somatic and explicitly FOT-oriented) therapists. Though modality skill does not reflect modality philosophy, there is alignment between the values of therapists as well as their modality choice and perceptions and uses of therapist expertise and power (Heinonen & Orlinsky, 2013; O'Shaughnessy et al., 2017).

In short, I can link my preference for relational therapy to many instances of feeling stifled or in some way hindered by injunctions on my own unfolding sense of Being-in-the-world. It is informative for later discussion to understand that these and similar experiences, from within an innately autistic-ADHD experience of the world, have (using this phrase ironically) shaped my aversion to behaviorism and empowered my increasing autonomous resolution to practice professionally and be-

in-the-world, as much as I can, in a relational manner. It is also valuable to understand these factors as uncomfortably juxtaposed. I have always, even before my time in psychology and again from an autistic-ADHD perspective, enjoyed thinking about complex ideas and integrating and attempting to comprehend different points of view.

I understand and may integrate cognitive and behavioral concepts–if that is what the person I am with desires or as a tentative offering if it seems spontaneously helpful, while maintaining a humanistic epistemology. In my view it is antithetical to the tenets of person-centered practice not to go where the person I am with wishes; if they feel a mindfulness exercise, for instance, or light homework, or a more structured framework would be helpful, I would collaborate on that insofar as I am comfortable practicing ethically. To not do so would deny the person's autonomy in seeking what they feel would best help them. Simultaneously, there is a tension in this way of working as it is not my default preference to practice from a place of worksheets, manualization, or therapist-guided structure.

Some of my therapeutic thinking may thus at times be described as pluralistic (Cooper, 2020). Attitudinally, however, I most value the person-centered principles and thinking of Carl Rogers as well as some of the phenomenological tenets of humanistic existentialism. To distill my developing mode of practice most essentially, I would consider it flexibly dialogical with an emphasis on anti-oppression, whether that concern sexuality and gender, neurotype, ethnicity, or any number of other sociocultural and psychosocial personal qualities.

Neurodiversity-affirming, or neuroaffirming therapy is not so dissimilar from person-centered approaches: It paradigmatically holds at its core a deep valuing of individual uniqueness and an appreciation for autonomy and self-determination which naturally leads to a certain client-centeredness with respect to nondirectivity. Furthermore, while in neuroaffirming therapy the reasoning for holding a position of sensitivity differs from the reasoning of the person-centered approaches—it is not just owed to a moral or ethical belief in the person's innate capacities but seen as a matter of maintaining professional competency and social justice as well as a belief in capacities—neuroaffirming therapy by nature prioritizes neurocultural sensitivity and curiosity (Chapman & Botha, 2022; Knopf, 2024; Roberts, 2024).

While their non-labeling nature coupled with principled nondirectivity and Rogers' philosophy of the person as an empowered agent of self-change (Brodley, 1986/2019, 1997; Moon et al., 2013; Rogers, 1951/2003) make them more naturally neuroinclusive than other ways of practicing therapy, when embodied purely on their own the client-centered attitudes are so potently nonpathologizing that they can, in my experience, erase important aspects of neurodivergent identity (Bolton, 2023a). The therapist can be so intent on not labeling a person that they do not consider how some labels, and putting words to experience, can help neurodivergent persons understand themselves.

Person-centered people, especially the more client-centered they lean, generally strive to relate to whomever they are with in a way that knows them without preconceptions (Rogers, 1951/2003, 1957). There is in this way of practicing and being an attitudinal emphasis, originating from Rogers' (1957) view that the process of therapy does not require anything particularly special of the therapist—even knowledge—to be a therapist, on receiving the other precisely as they are and unfold in unique expression of personhood while holding loosely to preconceived and formal notions of what makes them who they are. This stance is sensitive to personhood but not necessarily neuroculturally-sensitive, because it lacks an appreciation for the ways in which formal knowledge of neurological differences is a benefit within the interpersonal process of receiving and relating to individuals (Goldberg, 2023; Hillary, 2020; Muggleton et al., 2026). It has become a well-known finding of social psychology that neurocultural knowledge directly informs positive perception and destigmatization (Bolton & Ault, 2018; Cheng et al., 2025; Sasson et al., 2019; Turnock et al., 2022).

In contrast, I strive to be neuroculturally-sensitive and curious not only for the aforementioned reasons but also because I believe therapist knowledge of neurodiversity increases the client's sense of safety and enhances other positive qualitative aspects of the neurodivergent therapeutic experience (Bolton, 2023a; Jones et al., 2024). I believe that formal knowledge—of individual differences, conceptual frameworks like neurodiversity, and topics that are important to neurodivergent persons—increases the therapist's abilities and capacities to engage with systemic concerns and entities. Just as a feminism-informed therapist would paradigmatically center matters of relational and gender-based power, masculinity, and overarching patriarchy (Proctor & Napier,

2004), neuroaffirming therapy concerns such matters as internalized and structural neuro-ableism and working within and against neuronormative power structures (Chapman & Botha, 2022; Knopf, 2024; Tillett, 2023) in ways which render neurocultural sensitivity essential.

Focusing on Focusing ... Is (Potentially) Frustrating

Focusing-oriented therapy—and I say this as someone who appreciates Gendlin's work—might frustrate neurodivergent persons who are less bodily-attuned and correspondingly find it hard sensing or naming and putting words to feelings, or who have other interoceptive/somatic processing differences. It is important not to regard these experiences as individual flaws; they do not need “fixing” (Roberts, 2024).

The prompting of the focusing-oriented therapist to go into or find the felt sense of a situation or an inner experience might be perceived as invalidating, overly directive or leading, confusing (owing to the use of metaphor and conceptual abstraction), or lead to feelings of frustration, shame, or failure if the neurodivergent person cannot access or seem to access or describe it. By the same measure, sensory hypersensitivity or an abundance of awareness for bodily inner experiences might make focusing an overwhelming experience that requires greater care to safely work through. In contrast, hyposensitivity—as well as being alexithymic (Ferguson et al., 2023) or aphantasic (Zeman, 2024), and thus having trouble identifying emotional states or generating mental imagery—may reduce the vividness of or ability to engage with the process.

I am describing in the last paragraph experiences which often co-occur alongside autism but also manifest in isolation and alongside other forms of neurodivergence. Autistic people may just be more prone to co-occurring presentations and experiences of these phenomena, with research suggesting complex mediating roles of sensory and emotional processing (Acevedo et al., 2018; Dance et al., 2021; Dance et al., 2021; Keogh & Pearson, 2018; Liss et al., 2008; Monzel et al., 2024; Silvanto & Nagal, 2025). As a result, autistic people may find themselves particularly frustrated, for a variety of reasons, with FOT methods and focusing philosophies.

“ Isn't that the point of focusing-oriented therapy,” you ask, “…to help the client work through process-related frustrations and get in

touch with their symbolic sense of experiencing and move in that way toward different ways of living?" Yes, but: The conceptual felt sense or perception of a felt shift may be extremely abstract for the neurodivergent client, or involve on a physiological level non-benign effects in a similar manner as mindfulness and other somatic practices (Anālayo, 2019, 2021; Baer et al., 2019; Bolton, 2023a; Farb, 2024; Farias et al., 2020; Hall, 2020; Hutton, 2020; Hutton & Steel, 2021; Moreno-López, 2014; Welwood, 1980).

Possible experiences of psychosis, delusion, dissociation, depersonalization, fear, heightened anxiety or depression, re-traumatization, suicidal ideation, and physical health problems (Farias, 2024) all necessitate a careful, neuroculturally-informed (Bolton, 2023a; Heasman et al., 2024; Hutton, 2020; Hutton & Steel, 2021; Lunsky et al., 2022), trauma-sensitive (Treleaven, 2018) approach to experiential psychotherapy. Focusing, while theoretically distinct from a state of mindfulness and the process of meditation, is similar in practice to meditation and other somatic methods and thus shares in their problems and concerns which are relevant for work with neurodivergent persons. To disregard the cognitive or sensory individual differences of an autistic person and how they show up in the therapeutic space (Boldsen, 2022; Brake, 2024) is to likely make the process of focusing more difficult, even potentially harmful, for someone who may already experience the world very intensely (Markram & Markram, 2010; Murray et al., 2023).

For autistic people, the world tends to be louder and brighter. Tiny auditory details—a pen clicking or the tapping of fingers on a computer keyboard; the sound of someone chewing food; a whirring ceiling fan or the air conditioning unit—as well as more obvious sounds like the rumble of passing cars or people talking next table over in a restaurant, blast out like a firehose. Small sounds can be auditory bombs while lights appear more luminous and flood perception like flash grenades or, if not the right thermal temperature, can induce headaches or visual distortion. Physical sensations (the brushing or laying of fabric or feeling of cool air on skin, for example) can be unbearable, painful at worst and often constantly irritating and subtly distressing (Ferrari et al., 2025; Kalingel-Levi et al., 2022). Environmental information feels altogether more vivid; the world, if not adapted to, becoming more visceral and perceptually threatening if not violent (Boldsen, 2022; Charlton et al., 2021; Gray et

al., 2021; MacLennan et al., 2022; Memmott, 2023; Sibeoni et al., 2022; Strömberg et al., 2022; Parmar et al., 2021).

Many autistic people are thus, already, upon entering therapy, just below their perceptual breaking point. From a place of chronic burnout and fatigue, the result of frequent if not continual sensory overstimulation (as well as social masking; D. Miller et al., 2021), tolerance for the myriad cognitive and sensorial difficulties of experiential psychotherapy processes like but not limited to focusing may be low. Focusing-oriented therapy processes, then, may in some instances breach a person's perceptual limit and lead to negative outcomes such as those cognitive, sensorial, physical, and perceptual experiences described above. In turn, these outcomes may further and in conjunction lead to the autistic experiences of "meltdown" and "shutdown," by which, respectively, the person "feel[s] entirely overwhelmed accompanied by a lack of control and cumulative stress" (Phung et al., 2021, p. 2) and inwardly withdraws from their present environment while experiencing emotional pain (Lewis & Stevens, 2023; Paris et al., 2025; Phung et al., 2021).

The above factors need also to be considered by practitioners of emotion-focused therapy, wherein persons may be "…asked to become aware of and track sensorimotor processes (the sequence of physical sensations and impulses) as they progress through the body… and to be mindful of their internal experience," or "…to disregard thoughts that arise until the bodily sensations and impulses resolve or crystallize into a clear meaning and to symbolize the bodily-felt sense in words" (Greenberg, 2004, p. 6). To conclude this section, I return to my earlier statement that such therapist-derived requests of the person they are with might be perceived as invalidating, overly directive or leading, confusing, or link to feelings of frustration, shame, or failure if the person cannot access or seem to access or describe the conceptual or perceptual felt sense or bodily sensation. What follows is as much a commentary on my own practice as it is a stating of beliefs and ideas which I hope others might consider in their own practice. At the same time, I by no means intend this as a condition of worth on practitioners.

Emotion-Focused Techniques and the Perception of Therapist Control

Emotion-focused therapy has been validated as an "evidence-based practice" for work with autistic people (Robinson, 2014, 2018, 2020; Robinson & Elliott, 2017; Robinson & Kalawski, 2023). I particularly appreciate the care and sensitivity with which Robinson and Elliott (2017) approach their discussion of autism. Their conceptualization feels, for an empirical academic perspective, very gentle and respectful of the different ways autistic people experience the world. What feels jarring and problematic, with respect to the ability to be neuroaffirming, is the way EFT therapists seek to engage based on the appearance of certain, so-called "markers" by which emotional change can be brought about within the client. That is, they are actively looking for "in-session behaviors that signal that the client is ready to work on a particular problem" (Elliott & Greenberg, 2007, p. 246) so as to intervene with in-session client tasks, such as two-chair dialogue (Shahar et al., 2012), associated with therapeutic goals.

A Personal Process Anecdote

Here, I insert another personal contextualization of further discussion. In my own experiences learning about this way of doing therapy—and that is the crucial, driving distinction for me, epistemologically; it fundamentally involves a doing-to rather than a being-with—I have felt that the content discussed from meeting to meeting is client-led but the process of engaging with that content is therapist-structured and guided. It has felt like my university training in motivational interviewing (MI) strategies, which are described (W. Miller & Moyers, 2017) as "client-centered, directive" ways of strategically engaging with persons to elicit "change talk" and sustain patterns of growth and movement through therapeutic processes, especially when the person is ambivalent. Although as therapists we often work in settings where there are systemic pressures to produce change for and within clients, it is for me theoretically disingenuous to call any process-directive form of talk therapy also inherently client-centered; there is simply too much epistemological, ontological, philosophical, and logical contradiction with client-centered therapy's notion of principled nondirectivity. I do pluralistically incorporate principles of motivational interviewing in my

work, but from a position that acknowledges the inherent epistemological and client-motivated reasoning for doing so.

My pluralism is rooted deeply in client-centered as well as broader humanistic attitudes. I am sincerely curious about people (Bolton, 2024), from a place of deep empathy and compassionate sensitivity. I strive to accept people as they are and remain humbly grounded with the utmost respect for their psychological and social locations. I am not only willing but profoundly desirous to hold loosely to any directivity or power I might have within the therapeutic space (Bolton, 2023a, 2023b, 2024, 2025b). Because of my mild interest in and willingness to engage with other wide perspectives, I am not strictly client-centered but believe that a compassionate, empathic following of the person I am with to where they need me to go, even into moments of directivity, is the most principally person-centered stance I can take.

I am thus willing to offer directivity at the request of the person or if it seems, in my own clinical judgment, to be emerging out of my and the person's collaborative moment-to-moment relating. Yet, I am most at home in nondirectivity and close, empathic listening (Bolton, 2023a). This is the dialectic I operate within; the tension I hold and the dance I perform in therapeutic work; a both-and approach which seems, to me, most ethical and respectful of persons for the meeting of their varying needs. I echo Witty's powerful statement (2004, p. 23) that "any systematic process-directivity, intervention, or procedure that does not emerge from clients' creative participation in the relationship violates principled nondirectiveness" but also consider the eminent potentiality of a person's "creative participation" in collaborative dialogue.

I do not withhold directivity at times but any task or activity is only lightly and tentatively offered, with the caveat that it can be declined. Any offering is, on my side, dropped without question if met with uncertainty, hesitation, or client discomfort at being told what to do. Letting the person I am with request or choose to engage with process-experiential work, rather than pre-planning or guiding them into it, is my preference.

Perhaps all of this is just another way, my way, of interpreting "person-centeredness." I often reflect on Schmid's remark (2001, p. 53; see Witty's 2004 comments) that "[i]n person-centred therapy, the attempt to understand is never used 'in order to'" facilitate one's understanding of the person with whom one is working. Levitt's (2024)

sense of being nondirective-inspired but not strictly person-centered, even as I deeply value much of Rogers' thinking, resonates strongly when I consider how I want to show up in the work I do.

For me, empathy is not instrumental and directivity is not exercised out of a desire for power or control of the client's therapy experience. Still, in my view none of the process-experiential person-centered modalities can accurately be called inherently client-centered. This is especially true if the distinguishing characteristic of client-centered therapy is its nondirectivity (Witty, 2004) and is furthermore distinguished, following from Schmid (2001), if being person-centered is dependent on the existence of any therapist directivity at all. Whether a person-centered therapy must always contain all elements Rogers proposed is beyond my purpose here, but it is worth considering by everyone who engages with these ideas.

It is for these and other reasons I refer to myself as a relational therapist: The most ethical and intuitive way for me to be in the therapeutic space is my authentic self, cognizant of and neutralizing toward power dynamics, acceptant, empathic, compassionate, curious, directive if the moment inspires, willing to go psychologically where the person I am with needs; not holding to aspirations or beliefs that what I do or say is what helps the person; not believing, even, that the person will innately be helped by dialoguing with me. It is not my implicit goal to change the person I am with or to impose upon them. I view myself in the helping relationship such that my meeting with a person may be helpful or not—and that is not within my control. Still, even as a task is tentatively and gently offered, there is an unavoidable judgment by the so-called “skilled or expert therapist,” who naturally subsumes at least some expertise in the offering, that what they are bringing into the space will in some way be of benefit or use.

I recognize that when I say I am pluralistic and when I offer tasks. Indeed, my only real desire in the therapeutic relationship is to be curious and genuine, an animated and creative person collaborating in authentic but ethically, professionally, and therapeutically boundary-guarded conversation. Process-directivity, however it is generated in the therapeutic relationship and regardless of the modality in which it is embedded, is inherently authoritarian by its positioning of the therapist's intellect above that of the client's agency and self-expertise. Its implementation is not precluded by this but should be guarded by the

therapist's careful reflection on these matters: For instance, will this offering stifle my client's autonomy or is it in service of my own sense of being an “expert?” I see intellectual humility as a crucial safeguard in these matters.

Neuroaffirming Intentionality of the Therapist and Client Perception

Perhaps the most important question for therapy that aspires to be called neuroaffirming is whether the intentionality of the therapist matters. In assuming some degree of expertise and offering, even gently and tentatively, a focusing-oriented or emotion-focused task or technique or method, we are throwing away all the things that person-centered therapists claim to value–particularly the autonomy and agency of the person with whom we are meeting (Witty, 2004; Grant, 1990).

With respect to the development of EFT for work with autistic people, Robinson and Elliott (2017, p. 219) note that “the therapist is relatively active (but not necessarily directive) in identifying autistic process markers and collaborating with clients to set up therapeutic tasks.” It is nevertheless important to understand how therapist activity and directivity may be perceived similarly across modalities (Bodenmann et al., 2020; Bolton, 2023a; Timulak et al., 2022; Watson & Bedard, 2006). Research (e.g., Bolton & Lazzaro, 2020; Kneeland & Kisley, 2023; Manser et al., 2012) has revealed that laypersons may consider the change-based processes of EFT and CBT to be similar in that, regardless of their technical or theoretical mechanics or differences, they all attempt to facilitate some degree of change. It is the perception of being changed which the person understands. It matters little to them how they change; it is only important that their situation somehow improves; that they see a reduction in “symptoms” or feel happier, more capable or communicative, or experience whatever positive change means for them.

Person-centered thinkers actively recognize that directivity naturally constrains autonomy (Bolton, 2023a; Kirschenbaum & Henderson, 1989; Witty, 2004; Rogers, 1995; Schmid, 2001), but it is probably true that most people do not think about or understand such ontology. Research suggests autistic people, with their large collective negative experiencing of cognitive and behavioral therapies, might be so

attuned (Anderson, 2023; Andoni et al., 2024; Bolton, 2023a, 2025; Fuld & McKelvie, 2024; Graf-Kurtulus & Gelo, 2025; Hume, 2022; Jones et al., 2024; Jubenville-Wood, 2023; Kirkham, 2017; Kupferstein, 2018; Levinstein, 2018; Linden et al., 2023; Lipinski et al., 2019; Mazurek et al., 2023; Wilkenfeld & McCarthy, 2020).

Indeed, it is a result of autistic and other neurodivergent lived experiences that neuroaffirming therapy paradigms have become highly client-centered (Chapman & Botha, 2022; Knopf, 2024; Lai, 2023; Mills, 2023; Roberts, 2024). At the same time, there is research to suggest autistic people want directivity; they want solutions to problems which are not only personal but often systemic (Bolton, 2025a; Jubenville-Wood, 2023; Lipinski et al., 2019; Mazurek et al., 2023). This brings us again to the rhetorical but also quite practical question of whether the attitudinal stance of the practitioner matters. There is on some level a throwing-away of what the person-centered therapist values—but it is here, unlike the passage above, in service of what the person who is in therapy desires from the therapist. It is not about what the therapist wants for the person with whom they are working.

When we say that we are client-centered and practicing from a nondirective position, answering questions rarely and typically responding only with empathic understanding reflections (Brodley, 1998; Rogers, 1951/2003), and when we are process-directive within the auspices of FOT, EFT, MI, and so on, to expand beyond person-centered approaches–are we thinking in the best interests of the persons with whom we meet? Who are we even to judge that we know what may be such "best interest?" For me, to insist on practicing rigidly, adhering only to one manner of being in therapy, is not person-centered and certainly not holding to the client's interests.

To really hold in mind their "best interest," and this is not an injunction but an application of my belief onto my way of practicing, one must be willing to go where that person needs; to appropriately and ethically offer ideas, knowledge, techniques, methods, and so on in a tentative and compassionate manner. Consider the psychological impact of (non)directivity: Whereas too much therapeutic structure or directivity can be anathema to neurodivergent individuals, so also can be too little; the sudden freedom offered by the person-centered therapist for discussion of whatever the client wants may feel initially overwhelming. Silence and autonomy are heavy ideas for someone who

may have only ever been told (implicitly or explicitly) how to "do" therapy. What does that mean for the ways we work?

None of us is perfectly able to meet the edicts of any way of being or doing or not-doing in therapy all of the time. We inevitably stumble. That is the nature of being in relationship, whether our compass is moral, ethical, professional, or otherwise (Grant, 1985, 1990; Brodley, 1997). We must be careful, though, not to invalidate, gaslight, or diminish the epistemic authority of the person we are with, their "status as knowers, interpreters, and providers of information," as is often experienced by neurodivergent people (Chapman & Carel, 2022, p. 1).

Having stated all this, and while they do not majorly resonate with my clinical style, there are situations in which I might incorporate process-experiential perspectives. I believe that experiential, psychotherapist-guided or aided ways of working are made more neuroaffirmative not necessarily by changing their inherent processes but by the therapist's understanding and being sensitive to trauma, social justice, and neurodiversity paradigms of somatic experiencing (e.g., Dearly, 2019; Johnson, 2023; Keenan, 2024; Knopf, 2024; Mahler, 2023; Roberts, 2024; Treleaven, 2018; Walker, 2018). I also believe they are made neuroaffirming when they are enveloped within an environment where the client-centered attitudes are emphasized and therapist knowledge of neurodiversity–in both a learned, and client-created sense–is enhanced. This includes paying careful attention to, learning about, and being curious in relation to the client's neurotype, lived experiences, and individual differences.

Knowledge Acquisition Minimizes Harm Without Undermining Client-Centeredness

Any therapeutic modality may be experienced negatively or cause harm. To my point above, even client-centered attitudes can be harmful if the therapist is too dogmatic and rigid within them, insisting that by their practice and a little bit of phenomenological consideration of the client one may work with anyone. The attitudes of client-centered therapy have faced controversy given Rogers' (1957) contention that they are all that is necessary for therapeutic change. I am sure my views on neuroaffirming therapy (here and Bolton, 2023a, 2023b, 2023c) will be seen by many to contradict his statement that no specialized knowledge

is required of the therapist. I am also confident in stating that I do not believe Rogers' propositions are invalidated by my beliefs around person-centered neuroinclusivity. My person-centeredness is just one representation of these ideas; to quote David Hansen (2024), "I have a pluralistic attitude toward both [sic] people and also [sic] toward the person-centred approach itself."

When one is embodying the client-centered attitudes and has acquired knowledge of neurodivergent individual differences and neurodiversity paradigms, they are functioning in a manner which is conducive to enhancing the experience and safety of neurodivergent people in light of all the systemic concerns and individual differences experienced by the neurodivergent community. Constructive change, however, is not predicated on neuroinclusivity thus defined, in and of itself, and may still occur in its absence. I am not stating that the client-centered attitudes are insufficient in work with neurodivergent persons but that even broad acceptance of one's personhood can be augmented by an understanding of ways in which that person might be different or differentially experiences the myriad challenges of living. Cultural knowledge enhances empathy and phenomenological understanding (Khan, 2023). Informed by research (e.g., Corden et al., 2022) and lived experience, I believe therapists without neurocultural awareness will be less sensitive to neurodivergent needs, just as those who are not conscious of the needs of other community members will be less sensitive to them.

Indeed, what is culturally significant to a person depends on their unique knowledge, experiences, values, and perceptions (Glauser and Bozarth, 2002). Oftentimes relating to what someone brings to us, in life as well as therapy, requires we educate ourselves on relevant matters. Consider, for instance, that those identifying as autistic and LGBTQIA+ (Rosqvist et al., 2025) would benefit from understandings of minority stress theory (Kung, 2024; Maroney & Horne, 2022). But even beyond professional competency and empathic attunement, certain practice, such as in relation to matters of personal identity or concerning medication, is simply less ethical without advanced subject matter knowledge. Imagine working as a male therapist with a female-presenting person experiencing hormonal imbalances and not having any knowledge of relevant individual differences or health conditions. Whether the client's presenting concern is an LGBTQ+ matter or the

downstream mental health effects of a medical condition such as polycystic ovary syndrome, the therapist will struggle to empathize or perhaps might make erroneous attributions based on a lack of knowledge. They may come across as invalidating of or not caring about the client if it is perceived that they believe such domain-specific knowledge is irrelevant to understanding the client. And while we as therapists can certainly learn from our clients, it is, in my view, not the client's job to educate us on these matters.

Recognizing the historical, intersectional marginalization of neurodivergent persons (e.g., Gray-Hammond, 2022, 2023a, 2023b; Straus, 2013) is powerful relational activism that can only begin with the therapist understanding things from the client's frame of reference. Knowing about neurodiversity paradigms, the individual differences of neurodivergent persons, and matters important to neurodivergent persons does not take away from the therapist's ability to “hold minimal preconceptions, open receptivity, and minimal biases” (Glauser & Bozarth, 2002, p. 144).

Rather, it affirms the client's way of being and is an empathic entering-into of their world which shows the therapist's desire to relate with and to them. There is no abandoning of the basic attitudes which underlie the client-centered approach when learning about what is important or relevant to a client. The balancing of personal knowledge in relation to a group of people with in-the-moment experiencing of a person from that group is not just an essential dance mediating this process (Bolton, 2023a; Khan, 2023; Mullan, 2023) but in my view is a prerequisite of ethical practice and cornerstone of anti-oppressive practice more specifically.

Those ideas and ways of working might seem theoretically incongruent or contradictory from a classical person-centered perspective (Grant, 1990; Schmid, 2001; Witty, 2004), but, to me, make sense and are the bedrock of my relational practice. Seeking knowledge about neurodivergence is especially important for its crucial mitigation of the most insidious cause for harm: misunderstanding and stigma perpetuated by medicalized and outdated views of autism and other forms of neurodivergence. These have infiltrated the person-centered literature quite pervasively (e.g., Buck & Buck, 2006; Whitehead & Purvis, 2023; see Bolton, 2023a for discussion) and showed up in recent research (Bolton, 2025a) indicating most autistic people have

experienced harm specifically within the context of their therapeutic relationship.

Knowledge empowers the therapist to more readily empathize with marginalized identities from a place informed by client-centered attitudes (Glauser & Bozarth, 2002; Bolton, 2023a). Learning about people is at the heart of therapy, and neurodiversity education begins with a sensitive listening and affirmation of neurodivergence. Empathic expression is enhanced when understanding associated with knowledge is held not as the answer to the client, but tentatively alongside client sharing (Hume, 2022). Empathic attunement is a backdrop against which experiential therapy can be offered; knowledge can be an additional cipher to the client's codex of experiences, enabling a fuller understanding of their intersectional identities. I have attempted to convey that the underlying attitudes of client-centered therapy should not be forgotten by process-directive therapists working with neurodivergent persons, and need to be supported by knowledge of neurodiversity paradigms if they are to be neuroculturally sensitive. Embracing client-centered attitudes can be a starting point for reflection and for attaining knowledge of neurodivergence and neurodiversity. Failure to do so may result in a greater risk of harm in therapeutic work with neurodivergent persons.

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Person-Centered or Efficacy-Centered: A Discourse on Instrumental and Value Rationality in Psychotherapy

Yiyi Yee Liu (李梅花)[1]

When I was a child, my parents taught me, "You must study hard." Being a notorious "asker of a million whys," I naturally asked them, "Why?" They would reply, "So you can find a good job in the future." I asked again, "Why?" They continued to explain, "So you can earn money and raise children." "And then my children will continue to study hard, work hard, earn money, and raise their own children?" At this, they fell silent and told me to be quiet.

However, my young mind was captivated by the great mystery hidden within this exchange. I couldn't stop thinking about this "meaning trap," an inevitable infinite loop: you do one thing for the sake of another, and that other thing for the sake of yet another. When then, does the thing you are "for" ever arrive? (Aristotle, ca. 350 B.C.E./2009)

Growing up in contemporary China—a society lacking clear ultimate values—and in an atheistic family, I spent a long time unable to find a foundation for my own existence, nor could I understand the reasons for others' actions (Yan, 2009). For instance, I would observe the small convenience store next to my home. In China, the owner of such a store might only make a profit of 50 cents (about $0.069 USD) from selling a bottle of mineral water. This income is negligible compared to his other goods, and he has to expend significant effort to transport the stock and complete the transaction. So why did he bother to sell it? Why do something so unprofitable? For a long time, I couldn't imagine that a shop owner might stock items that were needed by his neighbors but

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yielded little profit, simply for their convenience. For a while, my only explanation was that he might gain a good reputation, which would then lead more people to buy other things from his store. I didn't realize that I had unconsciously adopted this mode of instrumental rationality, viewing human relationships themselves as a kind of transaction: "If I am good to you, it must be because I want something from you."

This worldview is a hollow loop. If a society's ultimate goal is to "make more money," the question then becomes, "What is the money for?" If the answer is, "For a better life," the system itself offers no definition of "better," aside from more material consumption. This is what the German sociologist Max Weber called "instrumental rationality" (Zweckrationalität)—a logic that is always in service of the next objective. And what I couldn't comprehend for a very long time was a different logic of action he called "value rationality" (Wertrationalität): where the meaning of an action lies not in what it can get you, but in the value inherent in the action itself (Weber, 1922/1978).

In this absence of meaning, I spent a decade in darkness and depression. I couldn't find a reason to act, and therefore, no reason to exist. When I got into university, found a job, and achieved things that were considered successes, I felt people around me infusing me with an air-like confidence. It was as if they had pumped an inflatable shell of "me" full of air, causing this thing perceived as "I" to instantly tower, while inside, there was nothing. I felt that none of it had anything to do with me. And when I lost my job and faced failure, this beautiful shell was instantly punctured. As the air rushed out, the shriveled exterior left my long-atrophied true self with nowhere to hide. I discovered I was nothing at all.

After graduating from university, amidst intense loneliness and depression, I stumbled upon the books of Carl Rogers and decided to try running an 8-person encounter group in my local area. In one session, a lesbian woman told us that her girlfriend had committed suicide the previous week. The room fell silent. No one told her to look on the bright side, no one comforted her by saying it would be okay, no one offered to find solutions, and no one tried to "fix" her pain. We all just sat there quietly, silently feeling her bone-deep grief. For the first time, I discovered that a "useless" emotion like grief, which almost everyone in society wants to reject, could exist here so uselessly. A person could simply be grieving, and her grief was not for the sake of any other goal.

Her grief itself was the destination. After that session, I broke the reserved norms of Chinese culture and hugged every person there. Our useless encounter group couldn't bring anyone any financial gain, nor could it solve any of their life problems. But in that moment, I felt that the relationship I had with them was the most worthwhile thing in the world.

After that, I became a psychotherapist. Yet, upon entering the profession, I found that the instrumental rationality that had haunted me since childhood was just as pervasive in this field. During my first internship, I found myself unable to explain to my supervisors the unique relationship I had built with my clients, one that made them feel understood and accepted. We were expected to focus on "symptoms," "interventions," and "treatment plans." I couldn't explain to them why I said this or that in a session, or what intention my "empathy" for the client served, or what goal it was directed toward. A faint voice inside me whispered, "Isn't understanding and acceptance a sufficient reason to do this? Do empathy and acceptance only become valuable when they lead to some other, seemingly more valuable, goal?" At the same time, a much louder voice in my head, amplified by the evaluations of my supervisors and teachers, questioned the value of my work.

So, for a long time, whenever my clients showed what would be considered positive changes, I felt confident. Whenever they didn't change or even got worse, I felt like a worthless therapist. But wait—wasn't this situation a perfect reenactment of the hollowness and false inflation I had experienced throughout my own development?

I continued my difficult exploration. I read Barry Grant, who wrote that "the client has the right to refuse what is efficacious" and that "client-centered therapy can be based entirely on moral principles." I read Moon and Rice, who wrote of their "refusal to ground the practice in the actualizing tendency, instead treating counseling as a moral practice." I read Barbra Brodley's work on the non-directive principle. I also saw the debates about the efficacy of the person-centered approach. The chasm in my heart grew wider. On one side lay the absolute value I had experienced in human relationships at so many moments, a value that needed no justification. On the other side, my legitimacy as a therapist, and even as a person, was being constantly defined by "effectiveness" and "quantification."

One day, I suddenly remembered the prostrating pilgrims I had seen many years ago. They were so devout. Traveling from the foot of the mountain to the temple at its peak, they would stop with every step, prostrate themselves fully on the ground in worship, then rise again, take another step, and prostrate once more. They could continue this for a month, walking this way every single day.

When I first saw them, my mind, filled with instrumental rationality, could not comprehend such an act. But on that idle afternoon, thinking of them, thinking of the words of Grant, Witty, Moon, and Rice, I suddenly understood the personal meaning of psychotherapy for me. I suddenly realized that my only way forward was to treat the counseling room as an ideal space for moral practice. I needed to understand my clients, to accept them, and to cultivate my own congruence. In doing so, I could form a relationship with my clients in which they could exist as ends in themselves, not as means to another end. This itself is the value. This relationship is everything.

I am not concerned with how "useful" this relationship is. Useful? What is useful? And to whom? If a reduction in anxiety is useful, then what is that reduction for? For a better job? What is a better job for? For a better life? And what is a better life? What is a better life for?

I see very clearly that once I base the value of psychotherapy on whether it is useful or not, its logic falls back into that hollow, infinite loop I mentioned earlier. One purpose serves another, and these purposes wind around each other without a clear beginning or end, and the value of a person's existence vanishes in this entanglement. But when I treat the client as an end in themself, and our relationship as an end in itself, the loop comes to a halt. There is nowhere else to go, because the present moment is the destination.

Since then, I have withdrawn from the war of proving our "usefulness" to this world of instrumental rationality. The person-centered approach does not need to prove its "usefulness" to earn its legitimacy, just as a person does not need to prove they can fulfill a certain function to earn their right to exist. In the "Dodo Bird Verdict" era of psychotherapy (where all therapies are found to be equally "effective"), I adhere to the principles of the person-centered approach, to non-directiveness and the core conditions, not because they are "more useful." I persist in this way because they possess a value that transcends

"usefulness." They offer what seems to be the only fully ethical way of being with another person.

In a society that demands everyone be "useful," "efficient," and a tool for achieving some goal, the most precious gift that person-centered therapy can offer is, perhaps, a relationship in which one is allowed to be "useless." Here, a person can simply be themselves, without having to be anything else. Their existence itself is the entire meaning. This, I believe, is the most profound respect I can offer another soul.

以人为中心还是以效果为中心：心理治疗中的工具理性与价值理性

Yiyi Yee Liu (李梅花)[2]

在我很小的时候，我的父母就教育我："你要好好读书"。作为一个著名的"十万个为什么"，我很自然地问他们："为什么呢？"他们于是回答："这样你以后才能找一个好工作。"我又问："为什么？"他们继续解释："这样你才能赚到钱，然后养小孩。""然后我的小孩继续好好读书，继续好好工作，继续赚钱，继续养小孩？"他们于是无话可说，让我闭嘴。

然而我那小小的心灵已经被这之中隐藏的巨大谜团所吸引。我无法停止地思考这个必然会导致无限循环的"意义圈套"：你做一件事情是为了另一件事情，而做另一件事情又是为了另一件事情。那么那个你"为了"的东西，到底什么时候才会到来呢？(Aristotle, ca. 350 B.C.E./2009)

在当代中国，一个缺乏明确终极价值指引的社会，一个无神论的家庭长大，我很长时间都找不到自身存在的根基，也想不通别人做事的理由。(Yan, 2009)例如我会看着家旁边的小卖部。在中国，这样一个小店卖一瓶矿泉水，老板只能赚 5 毛钱（相当于 0.069 美元）。那对于他的其他商品来说，是可以忽略不计的收入，而他需要付出更大的精力来运输货物，完成交易。然而为什么老板还要卖呢？无利可图的事情，为什么要做呢？在很长的时间里，我想不通一个小卖部老板为什么可能会为了方便自己的街坊领居而进一些大家需要，却没有什么利润的货。在一段时间里，我对这件事情唯一的解释就是：他可能因此获得别人的好评，从而有更多人在他店里买东西。我没有意识到自己没有选择地接受

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了这种工具理性的思维方式，从而把人际关系本身也看成了一种交易：“我对你好，一定是我想从你这里获得些什么”。

以人为中心，还是以“效用”为中心？——我的工具理性与价值理性之辨

这种价值观是一个空心的圈套。如果一个社会的终极目标是“赚更多的钱”，那么问题就变成了“钱是为了什么？”如果答案是：“为了更好的生活”，那么这个系统本身并没有对于“更好”的定义。德国社会学家马克思韦伯把这种行动的理由称之为“工具理性”，一种永远在为下一个目标服务的逻辑。而我在人生的很长时间内都无法理解的，是一种被他称之为“价值理性”的行动逻辑：行动的意义不在于它能换来什么，而在于行动本身就蕴含着价值。(Weber, 1922/1978)

在这样的意义缺失之下，我度过了黑暗抑郁十年。我找不到行动的理由，进而找不到存在的理由。在我考上大学，找到工作，取得一些被视作成功的事迹时，我感到身边的人向我灌注一种空气一般的自信。像是他们把某个我的充气外壳注入了许多空气，于是那个被看做是“我”的事物瞬间变得高大，而它的里面，却什么都没有。我感到一切都与我无关。而当我失业，遭遇失败之后，这个漂亮的外壳瞬间被扎破，气流从小孔中涌出，干瘪的外壳让我那个早已极度萎缩的真实存在无处遁形。我发现我什么都不是。

大学毕业之后，在剧烈的孤独和抑郁之中，我无意间发现了卡尔罗杰斯的书，于是试着在当地办了一个 8 人的会心团体。在一次团体之中，一个女同性恋者告诉我们她的女朋友上周刚刚自杀了。当时现场鸦雀无声。没有人劝她看开一点，没有人安慰她说这没事的，没有人帮她找找解决办法，没有人帮她“处理”自己的痛苦。大家只是这么静静地坐着，静静地感受她那深入骨髓的悲伤。我第一次发现，原来一个如此“无用”，在社会中尽人都想排斥的“悲伤”，居然可以在这里如此无用地存在。原来一个人可以只是悲伤，而她的悲伤并不是为了任何一个别的目标。她的悲伤本身就是目标。在那次会后，我打破了中国人含蓄的常规，拥抱了在场的每一个人。我们这个无用的会心团体无法带给任何人任何经济上的收益，甚至无法解决他们生活中的任何问题。而在那一刻，我感到我与他们的关系本身，就是这个世界上最值得拥有的东西。

在那之后，我成为了一名心理咨询师。然而在进入这个行业之后，我发现从小就困扰着我的那种如影随形的工具理性依然在这个行业中如

影随形。在我第一次实习的时候，我发现我无法向我的督导说明我与我的来访者建立了多么独一无二，让他们感到被理解和接纳的关系。因为我们需要关注的是“症状”、“干预”、“治疗计划”。我无法向他们解释我为什么要在咨询中说这句话或者说那句话，我对来访者的“共情”又是有什么意图，朝向一个怎样的目标。我心里有一个微弱的声音在说：“难道理解和接纳本身不足以成为我做这件事的理由吗？难道只有这些共情和接纳导向了另一个看起来更有价值的目标时，它们才顺便变得有价值吗？”而与此同时，我心里那个更加巨大的声音，加上那些督导和老师评价我的声音，都在质疑我工作的价值。

于是在很长一段时间里，每当我的来访者有一些会被他们认为是积极的变化时，我就感到自信；每当他们没有变化或者变得更遭了，我就觉得我自己是一个一无是处的咨询师。等等，难道这种处境不正是完美地复现了我成长过程中一直体会到的空心和虚假的膨胀吗？

我继续艰难地探索着。我看到 Barry Grant 写：“来访者有权选择无效的咨询”、“以人为中心咨询可以完全建立在道德原则之上”；我看到 Moon 和 Rice 写他们“拒绝以实现倾向作为实践的根基，而把咨询当做一种道德实践”；我读到 Barbra Brodley 的非指导性原则。我同样看到那些关于以人为中心方法有效性的争论。我心里的裂口被越撑越大，裂口的这边，是我在许多时刻体会到的一些无需论证的，存在于人类关系之中的绝对价值；另一边，是我作为一个咨询师存在的合理性，甚至作为一个人存在的合理性不断被“有效”和“量化”定义着。

有一天我突然想起很多年前遇见的那些磕长头的朝圣者。他们是如此虔诚，从山脚前往山顶的寺庙，每走一步就停下来，把身子完全伏在地面上跪拜，然后重新站起来，再走一步，再跪拜一次。他们能这样走上一个月，每天这样行走。

在我曾经看到他们的时候，我那充满了工具理性的脑子无法理解这种行为。而在那个无所事事的午后，我脑子里想着他们，想着 Grant，Marge，Moon 和 Rice 说过的话，突然明白了心理咨询对我个人的意义。我突然理解了，我唯一的出路就是把咨询室当成一个理想的道德实践的场所。我需要去理解来访者，需要去接纳来访者，我需要培养自己的一致性。这样，我跟我的来访者形成一种关系，他们在这种关系之中可以作为目的本身，而不是作为实现另一个目标的手段而存在。这本身就是价值，这种关系就是全部。

我并不关心这种关系如何“有用”。有用？什么是有用？是对谁有用？如果焦虑情绪的减少是有用，那么焦虑情绪减少是为了什么？为了更好的工作？更好的工作是为了什么？为了更好的生活？什么是更好的生活？更好的生活是为了什么？

我很清晰地看到，一旦我将心理咨询的价值建立在有用还是没用之上，这件事情的逻辑就又回到了我前面说到的那种空心的无限循环之中。一个目的是为了另一个目的，这些目的与目的互相绕来绕去，找不到起源和尽头在哪里，人的存在价值就在这种缠绕之中消失了。而当我把来访者当做目的本身，把我们的关系当做目的本身，这个循环就戛然而止。没有什么需要去的地方，因为当下就是目的地。

自此我也退出了向这个工具理性的世界证明我们“有用”的战争。以人为中心方法不需要证明自己“有用”，才有存在的合法性。就像一个人不需要证明自己能够达成某种功能，才能获得存在的理由一样。在心理咨询的“渡渡鸟时代”（所有方法都被证明同样“有效”的时代），我坚持以人为中心的原则，坚持非指导性和核心条件，不是因为他们“更有用”。我之所以这样坚持，是因为他们有“有用”之外的价值。他们提供了一种似乎是唯一完全合乎伦理的，对待人的方式。

在一个要求每个人都必须“有用”、必须“高效”、必须成为达成某个目标的工具的社会里，以人为中心疗法所能提供的最珍贵的礼物，或许就是一段被允许“无用”的关系。在这里，一个人可以只是他自己，而不必成为任何别的什么。其存在本身，就是全部的意义。

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"Marching Out of Time, to My Own Beat Now; the Only Way I Know!" Inviting Congruence, Centering Identity, and Unmasking "ADHD"

Matthew J. Bolton[1] and Cheryl Leong[2]

From both deeply personal and professional experience, we perceive that the psychotherapy field promotes evidence-based cognitive-behavioral conceptualizations as most suitable for neurodivergent (ND) persons, by which term we mean those who would be classified with psychiatric notions of mental "disorder" and "illness," to the practical exclusion of other understandings (Bolton, 2023a; Champ, 2021). In close association, neuronormativity is increasingly recognized as a social-norming frame which consciously centers human experience relative to "normal" statistical averages and casts all others (including ours) as "abnormal" (Catala, 2023; Chapman, 2023; Walker, 2021). We have witnessed the impact of this pathologizing lens negatively impacting our clients' sense of being in painfully profound and multidimensional ways.

We have continually witnessed how such frames manufacture an unsupportive dichotomy around notions of difference and personhood; they foster a culture of care in which able-bodied and neurotypical bodies and minds are centered and privileged and disabled and

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neurodivergent bodies and minds are ostracized. Under neuronormativity, closely aligned as it is with productivity-based economic values (Chapman, 2023), people are frequently evaluated and experience conditions of worth, with those experiencing mental distress positioned as “unstable” or “unwell.” Psychotherapeutic focus shifts, in turn, from supporting people in living with their unique experiences toward ideas of “treatment,” “cure,” and “usefulness” within society (Fuld & McKelvie, 2024; Bolton, 2023a).

The spread of neuronormativity throughout the mental health field has influenced all psychotherapeutic orientations but perhaps, in our view, has had its most insidious effects on person-centered approaches. Alongside a gradual dilution of, and departure from, Carl Rogers' foundational therapeutic values, contemporary person-centered care frameworks have arisen, emphasizing the elicitation of individuals' values and preferences and less of the relational conditions that we see and value as originally intended to facilitate organismic growth (Brummel-Smith et al., 2016).

Within this shift, as Bazzano (2016) observes, the worth of the individual increasingly risks measurement relative to productivity rather than recognition of inherent humanity and wellbeing. The broader ideological schism between humanism and normativism that this phenomenon contextualizes echoes earlier tensions between the client-centered approach and behaviorism (C. Rogers & Skinner, 1956; Kirschenbaum & Henderson, 1989). Against this historical backdrop, we examine neuronormativity and the pathologization of “ADHD” in person-centered therapy while extending person-centered discussions concerning neurodivergence more generally.

Uncritical Use of Psychiatric Frameworks

Person-centered ideas integrate readily with social models of disability (Bolton, 2023a, 2023b, 2026). Carl Rogers' (1980/1995a) “Person of Tomorrow,” characterized by psychological health amidst complexity, openness, congruence, internal locus of control, care for others and the environment, and distrust of rigid institutions, could well be today's ND individual. The social model of disability shows how ND people can thrive (Chapman, 2020, 2021; Chapman & Carel, 2022; Dantas et al., 2025); ND traits link to creativity, curiosity, and associated desire for

new experiences (e.g., in relation to autism and “ADHD”, Collins & Lemerond, 2026; Leong & Graichen, 2024; Meilleur et al., 2024; Poli et al., 2024; Robdale, 2024; Scheerer et al., 2021; Smees et al., 2025; Wassell, 2026; White, 2019), and ND people strongly desire autonomy and authenticity (e.g., in relation to autism and “ADHD”, Bhattacharya et al., 2025; Bolton & Ault, 2025a, 2025b; Kingdon, 2024; Morsink et al., 2021; Ryan et al., 202[34]).

Carl Rogers (1961/1995b) departed from and stood against psychiatric labeling. Other perspectives within the orientation, to our concern, have leaned more heavily on psychiatric language and labeling traditions, reflecting how deeply embedded these paradigms are and how they may constrain or narrow our understanding of neurodivergent lives (Bolton, 2023a). In observing how rare it remains for contemporary person-centered perspectives to encourage neurodivergent clients simply to be as they are, we are invited to reflect on what may have been lost. We gently call upon our colleagues to return to the heart of person-centered practice, so that neurodivergent clients can safely encounter spaces where they are welcomed to simply be (Bolton, 2023a, 2026).

The very title of Person-Centered Practice at the Difficult Edge (Pearce & Sommerbeck, 2014), the eminent person-centered text on neurodivergence as of this writing, though never using that term, implies the subjects of its authors' writings–learning-disabled, autistic, and schizophrenic-psychotic spectrum persons; all ND–function in myriad ways that are difficult to relate to. The summary states that the book “presents accounts of the practice of the person-centred approach with people suffering from a range of severe and enduring conditions [italics ours, for emphasis].” From there, various authors present pathologized

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[3] Neurodivergent people, further, demonstrate internal locus of control (Elliott, 2021; Neff, 2025; Nguyen et al., 2020; Shepherdson et al., 2024; Williams, 2018), experience justice sensitivity and non-hierarchical morality (Bertschy et al., 2020; Birmingham et al., 2015; Caldwell-Harris & Schwartz, 2023; Gray-Hammond, 2024; Greenberg et al., 2024; Kapp, 2016; Patil et al., 2016; Ringshaw et al., 2022; Qian et al., 2022), show sensitivity for the environment (Bishop et al., 2023; Bolton et al., 2020; Friedman et al., 2024; Friedman et al., 2025; Oldfield, 2024; Thunberg et al., 2018; Thunberg, 2019). Their drives for autonomy and congruence evoke imagery of flowers growing through concrete towards the crepuscular sunrays of nonconformity and individuality (Botha & Gillespie-Lynch, 2022; Palmiotto, 2024; Straus, 2014; Thomson, 2025; Woods, 2023; Yafai et al., 2013).

accounts of neurodivergence. Bolton (2023a) provides a more in-depth discussion. [4]

With relevance to the intersection between person-centered therapy and clinical discussion of neurodivergence, Oberreiter (2021; published in *Person-Centered & Experiential Psychotherapies*, *PCEP*), writing on Carl Rogers' evolution in referring to schizophrenia and psychosis over the course of his career, did not adopt Rogers' own language for these concepts and instead leaned into pathology paradigms.

Lewis (2024, again in PCEP) further reinforced neuronormative and pathologizing language around "ADHD" when discussing the experiences of ADHD-identifying therapists. Whitehead and Purvis (2023) primarily integrate psychoanalytic understanding of autism, as a perpetual state of psychological infancy out of which autistic children never emerge (Evans, 2013), to the furtherance of Bettelheimian myths about autism (such as the "refrigerator mother" theory; Silberman, 2015) and the dilution of person-centered therapeutic perspectives on working with autistic people.

Discussion on "ADHD" as a client characteristic is practically non-existent in the person-centered therapy literature. References are not in the person-centered sense commonly understood by readers of this journal but within "person-centered care" frameworks that adopt the language of client-centeredness without reflecting its underlying principles. For instance, they emphasize the promotion of client autonomy without an accompanying attitudinal stance characterized by empathic attunement and congruence of the practitioner (Brummel-Smith et al., 2016; Eklund et al., 2019).

For as much potential as it holds to draw attention to ways ADHD-identifying persons experience conditions of worth, the single person-centered therapeutic reference to "ADHD" we have been able to find (Harvard, 2023) describes this ND state of being as a "miserable" disability qualified by myriad "impairments" of executive processing (e.g., with regard to memory, behavioral inhibition, emotion regulation) for which the only effective "treatment" is medication. Harvard (2023) further remarks, in a bevy of statements echoing generalizations of ND

[4] The book also includes references to adolescents; experiences of dementia which we consider to be an age- and/or memory-related form of neurodivergence, and various forms of traumatic experience. Trauma is recognized in neurodiversity paradigms as acquired neurodivergence, owing to its rewiring of neural pathways (Bolton, 2023a).

experience (Enright, 2021; A. Grant, 2025), that there are "…many people who can be said to have ADHD, but at a sub-clinical level," and invokes Russell Barkley (e.g., 2019) whose views on "ADHD" are prominently non-neuroaffirming.

Problems of Diagnostic Frameworks

The very name *attention deficit hyperactivity disorder* positions "ADHD" identity as something broken. "Hyperactivity" is conceptually accessible but, due to neuronormative assumptions and expectations around "appropriate" activity, often carries negative connotations regarding "excessive" motor behavior (American Psychiatric Association, 2022; Werry, 1968). Neuronormativity reduces the complex realities of "ADHD" neurotrait expression to an oversimplified account that fits neatly within diagnostic frameworks but fails to capture a human experience that is far more nuanced and shaped by context (Leong & Graichen, 2024). As a therapist, author CL has observed that many of her "ADHD" neurotrait-identifying clients do not experience "deficits" of attention but rather *differences in stimulation response and attentional variability* that see them moving between hyperfocus, creative absorption, and broad perceptual scanning (Calderone et al., 2014; Champ et al., 2024; Grotewiel et al., 2022; Haigh & Buckby, 2024; Parents League of New York, 2021; Weinhardt et al., 2025).
Person-centered ideas integrate readily with social models of disability

The very name attention deficit hyperactivity disorder positions "ADHD" identity as something broken. "Hyperactivity" is conceptually accessible but, due to neuronormative assumptions and expectations around "appropriate" activity, often carries negative connotations regarding "excessive" motor behavior (American Psychiatric Association, 2022; Werry, 1968). Neuronormativity reduces the complex realities of "ADHD" neurotrait expression to an oversimplified account that fits neatly within diagnostic frameworks but fails to capture a human experience that is far more nuanced and shaped by context (Leong & Graichen, 2024). As a therapist, author CL has observed that many of her "ADHD" neurotrait-identifying clients do not experience "deficits" of attention but rather differences in stimulation response and attentional variability that see them moving between hyperfocus, creative absorption, and broad perceptual scanning (Calderone et al., 2014;

Champ et al., 2024; Grotewiel et al., 2022; Haigh & Buckby, 2024; Parents League of New York, 2021; Weinhardt et al., 2025).

Attention may flow like a river, creep tentatively, or appear fragmented. Competition between intrinsic and external motivational processes may lead to a sense of inner overwhelm, or an inability to choose what task to pursue from moment-to-moment, by which the person becomes panicked, paralyzed, or stereotypically "unfocused" (Dwyer et al., 2024; Irvine et al., 2024; Rosqvist et al., 2023). In neuroaffirming accounts, a lack of focus is not the reason that people with the "ADHD" neurotrait cannot concentrate or center their attention. Rather, in these viewpoints it is the pulling and stretching of attentional capacities based on the person's interests and motivations that gives the appearance of a lack of focus (Rosqvist et al., 2023). Variable Attention Stimulus Trait (VAST; Hallowell & Ratey, 2022) is one neuroaffirming term and framework describing the qualities and characteristics of "ADHD."

VAST offers a neuroaffirming lens for understanding attentional variability through a view of attention as a neurotrait that interacts dynamically with environmental conditions. The term was originally suggested by journalist Carrie Feibel and later popularized in clinical discourse by Hallowell and Ratey (2022). Person-centered therapy can thus conceptualize attentional variability as a natural neurotrait rather than a deficit, situating therapeutic work within empathy, unconditional positive regard, and congruence (C. Rogers, 1957, 1959).

From this perspective, the therapist's task is not to "correct" attentional functioning but to cultivate a relational climate in which clients experiencing variable attention can explore their moment-to-moment experiential field without evaluation or pathologization, facilitating greater organismic trust and self-acceptance. Within such a facilitative environment that also honors their choices of identity and identification (Bolton, 2023a), clients are supported in identifying the contextual, sensory, and relational conditions under which their engagement becomes more accessible and empowered toward increased self-directed regulation and authenticity. The integration of VAST and person-centered therapy frameworks aligns the person-centered emphasis on actualizing tendencies with neuroaffirming paradigms, reframing attentional difference as meaningful expression of adaptive organismic processes rather than "dysfunction."

By centering what is "lacking," diagnostic frameworks, in contrast, conceal nuanced reality and ignore that "ADHD" often empowers imaginative leaps, unexpected connections, and divergent insights (Champ et al., 2024; Grotewiel et al., 2022; Weinhardt et al., 2025). Kosaka and colleagues (Kosaka et al., 2019) note that masking behaviors—learned strategies for camouflaging neurodivergence in response to parental and other socialization—associated with the "ADHD" neurotrait can, especially for girls (Grimell et al., 2025; Martin, 2024), render the condition invisible in childhood, only to resurface under the weight of adult stress.

Masking and the Silencing of the Self Through Incongruence

Leong and Graichen (2024) conceptualize ADHD masking as a social adaptation through which individuals may camouflage their neurodivergence in response to dominant neurotypical expectations, drawing attention to the relational and contextual conditions that shape these adaptive processes. From this perspective, masking is understood not solely as a coping strategy with a developmental trajectory but as a response of incongruence emerging within interpersonal and sociocultural environments. It is often insufficiently recognized within conventional diagnostic framings of neurodivergent ways of being (Leong & Graichen, 2024).

The mental ill health outcomes associated with masking can emerge early in development. Beyond anxiety and depression, individuals who engage in "ADHD" masking frequently describe experiences of stress, embarrassment, and despair, reflecting the sustained emotional and cognitive effort involved in concealing ND traits (Rowney-Smith et al., 2024). Ongoing demands to suppress or compensate for "ADHD" neurotrait expressions may also influence daily life, career participation, and overall quality of life, positioning masking as a significant psychosocial factor in understanding longer-term developmental and relational outcomes (Rogers, 1957, 1959; Rowney-Smith et al., 2024).

Emerging evidence (Bolton et al., 2022; Bolton & Ault, 2025a) suggests that masking, as an ND form of incongruence, develops in relation to conditions of worth experienced in adolescence as well as adulthood, aligning with Carl Rogers' original theory of personality (Rogers, 1957, 1959, 1995b). External expectations and demands on

personhood, neurodivergent or otherwise, distort the organismic valuing process so that injunctions for how one "should be" shape the individual into someone outwardly defensive (Bolton & Ault, 2025a; Pearson, 1969; Rogers, 1964), with their congruent self hidden so they may receive conditional positive regard.

Many ND clients have described to us, MJB and CL, years of contorting themselves to meet external expectations by which they are evaluated and judged–silencing their curiosity, suppressing sensory needs, and so on. The myriad ways in which ND persons mask often lead to anxiety, depression, burnout, fear of criticism and rejection, and a sense of estrangement from one's authentic self (Bolton & Ault, 2025a; Grimell et al., 2025; Kosaka et al., 2019; Miller et al., 2021; Mylett, 2022; Nelson, 2025; Rowney-Smith et al., 2024). Developmentally, neuronormative standards shape not only diagnostic categories but also family systems and wider social structures. Age-related milestones for speech, motor skill, memory, and attention are external conditions of worth judged against neurotypical norms; divergence becomes "delay" or "disorder." The result is a system where "ADHD" neurotrait identity is continually invalidated for individuals of all sociocultural backgrounds and across the lifespan (Belisle, 2022; Chawla et al., 2025; Erlandsson et al., 2022; Ginapp et al., 2023; Godfrey-Harris, 2023; Kistler, 2022; Mansfield & Soni, 2024; Moore et al., 2025; Nelson, 2025; Slobodin et al., 2020; Pryke-Hobbes et al., 2023; Ripley & McEwan-Thompson, 2025; Visser et al., 2024).

Camouflaging behaviors among adolescent girls with "ADHD" diagnoses have been linked to poorer mental health outcomes (McKinney et al., 2024). ADHD-identifying adults who receive professional diagnoses are often labeled "late onset" or have difficulties misattributed to other conditions (Caye et al., 2017; Faraone et al., 2006; Long & Coats, 2022; Sibley et al., 2018). These harmful shortcomings reveal how diagnostic frameworks prioritize neurotypical expectations and, further, systemically enforce normative developmental perspectives over the lived experience of ND identities. "Symptom" categorization also invites misdiagnosis and medication misuse (Abdelnour et al., 2022; Banaschewski et al., 2024; Chan et al., 2023; Gascon et al., 2022; Massuti et al., 2021; Moustafa et al., 2022).

The *DSM-5* (revised; American Psychiatric Association, 2022) has expanded its criteria but remains divorced from systemic and relational

contexts. An inherent focus on *deficit* and *dysfunction* neglects the ways ableism and neuronormativity–in the form of prejudice on the basis of perceived (in)ability and social norms that privilege neurotypical viewpoints and hierarchies–structure the very struggles ADHD-identifying and other ND people bring into therapy (Bolton, 2023a; Comas-Díaz & Rivera, 2020; Catala, 2023). Diagnostic frameworks thus risk perpetuating harm by reifying pathology rather than recognizing ADHD as a valid and valuable identity. They also distract from the social understanding of disability and ableism in family and wider societal systems.

Person-Centered Approach, Meet the Social Model of Disability

While psychiatric labels can hold powerful insights and meaning for ND persons (e.g., Bolton, 2023a; Chang & Bassman, 2025; A. Grant et al., 2025), the diagnostic frameworks from which they derive conflate and paint-over the complexity of "ADHD" identity, misread masking as maladaptive coping rather than a survival mechanism in the face of oppressive systems and personal views and biases, and neglect the very harmful influences of systemic oppression.

By contrast, neurodiversity-affirming lenses reclaim "ADHD" as archetype, identity, and biodiversity (Bolton, 2023a; Leong & Graichen, 2024; Chapman & Botha, 2022; Rosqvist et al., 2023). The social model of disability locates mental health and psychological "problems" not within individuals but in the lack of accommodations for them within the environment. We feel called to express our growing conviction that neurodiversity-affirming therapy draws on a social model framework that beautifully resonates with the core attitudes of client-centered practice (Bolton, 2023a; Bolton, 2026; Chapman & Botha, 2022; Hume, 2022; Jones et al., 2024; Lai, 2023; Roberts, 2022).

Social model and person-centered perspectives converge strongly around the idea that many of the challenges faced by ADHD-identifying individuals, especially those related to masking, are largely due to societal inflexibilities and conditions of worth rather than inherent "deficits" of individuals (Bej, 2025; Bolton, 2023a; C. Rogers, 1957, 1959; Flower et al., 2025; Lai, 2023; Lerner et al., 2023).

Indeed, the social model of disability brings us back to the attitudinal roots of the person-centered approach: Through our sense of presence

(Schmid, 2002) and embodiment of empathy, congruence, and unconditional positive regard, we are empowered to sit with individuals *as they are* in appreciation for their lived experiences and socially-situated identities (Bolton, 2023a; Bolton, 2024; Bolton, 2026; Hume, 2022; Jones et al., 2024; Lai, 2023). While conditions of worth are not the end-all-be-all of distress, recognizing ND client experiences of conditional regard and understanding their neurodivergence and other aspects of lived experience (Bolton, 2026) contributes to our capacity to empower and safely work with ND clients. Participation in therapy can thus go forth within the context of the client's courageous act of unmasking by which they may feel empowered to explore and express themselves without fear of rejection, free from the injunctions of their usual environments (Bolton, 2023a, 2024a, 2023b; Hume, 2022; Jones et al., 2024).

"ADHD" as Archetype and Identity

When we step outside the limitations of psycho-diagnostic language, a different picture of "ADHD" emerges. LoPorto (2005; and see Leong & Graichen, 2024) described "ADHD" identity as the Da Vinci archetype, evoking Leonardo da Vinci's *Renaissance man* moniker for his vast imagination, wide experimentation, brilliance, and originality (History.com, 2009).

Neuroscientific research has linked the DRD4 dopamine receptor gene to novelty-seeking, risk-taking, and creativity (Hartmann, 2005; Lynn et al., 2005; Matthews & Butler, 2011). We can use these and other emergent findings of brain-based inquiry undertaken through neurodivergent-affirming lenses (e.g., Goldberg, 2023; Le Cunff et al., 2023; Sonuga-Barke et al., 2022; Xia et al., 2024) to expand beyond deficiency-based narratives of "ADHD." Rather, far from being "disordered," "ADHD" neurotraits can be understood as part of human biodiversity with evolutionary purpose. ADHD-identifying adults often display heightened entrepreneurial drive and creative output, particularly when motivation is aligned with interest and passion (Cho & Jiang, 2021; Moore et al., 2019; Wiklund et al., 2016). Such findings suggest "ADHD symptoms" may in fact be qualities that have fueled human progress.

Affirmation of "ADHD" identity as archetypal offers one way therapy can become a space in which clients reclaim pride in their way of being and learn to live more fully with both the strengths and challenges associated with neurodivergence. Author CL has observed this process in clinical work with ADHD-identifying clients. Drawing on Natalie Rogers' person-centered expressive arts therapy framework (N. Rogers et al., 2012), she proposes that compassionate witnessing of clients' archetypal imagery from a place of empathy, congruence, and unconditional positive regard supports therapeutic engagement.

Such embodied, compassionate witnessing enables neurodivergent clients to approach, and gradually integrate, those aspects of their inner experience that may previously have been experienced as unacceptable, denied, or rejected, fostering greater psychological wholeness and continuity of self. By decentering neuronormativity, therapists create relational spaces that honor rather than suppress ND expression (McVey et al., 2023).

Concluding Thoughts

We hope that this article has begun to illuminate that, through social-relational and systemic models of "disability," "ADHD" may not be a neurological or mental health "disorder" of attention or behavior but a complex way of being that becomes disabling largely through context—especially social context. The social model of "disability" invites us as therapists to ask not "what is wrong with this person?" but "what conditions make this person's way of being unworkable to the moment, and how might we change to better support the person?" This subtle reframe, evoking the double empathy perspective (Milton et al., 2022), shifts attributions of supposed and apparent difficulties experienced by the individual from the person to the mismatch between them and their environment, indeed between them and their therapist, affirming that the task of the therapist or counselor is not to "normalize" the client but to create conditions where their natural ways of being and relating can be valued and sustained (Barnes, 2019; Oliver, 1996).

From both our professional and lived experience, *decentering neuronormativity* involves recognizing that the problem does not reside within "ADHD" experience itself, but within the societal standards that have defined our ways of being as deviant. We take a liberation

psychology perspective where the role of being a therapist shifts away from fixing or correcting "ADHD" and moving toward compassionately dismantling both internalized and systemic neuro-ableism—a form of ableism that constrains the authentic expression of people who identify with the ADHD neurotrait (Comas-Díaz & Rivera, 2020; Mullan, 2023).

This perspective aligns naturally with person-centered therapeutic thinking and practice. Empathy asks us into the client's world nonjudgmentally. Unconditional positive regard invites us to curiously value identity *as it is*, not as society says it "should be" (Bolton, 2024; Rogers, 1961/1995b). Congruence calls us to embody authenticity and to model a relationship where difference is embraced rather than erased. Through the sharing of these attitudes, we demonstrate that we are willing to sit in the mud and journey alongside the people with whom we work, with compassion for the nuances of their experience of the world.

Typically, at the start of work together neither we nor the client has an answer to, nor any sense of a direction for, their challenges or the work undertaken in therapy. We relate to those with whom we work from a principled insistence that they know themselves best and that we never could know their psychological terrain (B. Grant, 1985, 1990, 2025). We consider that they have within themselves the capacity to find their way forward in a manner satisfactory to themselves, which empowers the life they wish to live (C. Rogers, 1951/2021, 1957).

It is the lack of preconception in our sense of the people with whom we work and our willingness to again and again and again approach them and affirm their essential and authentic way of being with sincere curiosity, to recognize them *as they are* (Bolton, 2024a; C. Rogers, 1995a, 1995b) that perhaps most aptly aligns person-centered and social model perspectives. We recognize and allow room for complexity and uncertainty of person and situation.

Our way of working, that is, authors MJB and CL, which we share here, considers social-relational-cultural-systemic context at all levels of therapeutic work. We believe the decentering of neuronormativity is not an add-on to but a deepening of our person-centered practice. We invite readers to reflect on their own practice with neurodivergent, and indeed all, clients, and to consider how you do or do not explicitly acknowledge and navigate neuronormativity. Our ethical commitment to dignity, equality, and liberation does not merely suggest but embraces and, indeed, advocates for an attitudinal *living-out* of empathy, congruence,

and unconditional positive regard. That is how we affirm client congruence and dismantle as well as transcend experiences of shame imposed by the deficit-based narratives of neuronormativity. In turn, the therapeutic space becomes a place of liberation, where "ADHD" *being* is honored as part of the rich tapestry of human diversity.

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Client-Centered Supervision: Development Through Relationship[1]

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Client-centered supervision is an orientation-specific supervision grounded in the core teachings of Carl Rogers' client-centered therapy (Rogers, 1942; 1957). This model highlights the supervisee's natural ability to grow and direct their own development, viewing them as the main agent of change (Rogers, 1992; Smith, 2009). A key aspect of this approach is building a trusting supervisory relationship grounded in empathy, attentive engagement, and collaboration (Rogers, 1957; Talley & Jones, 2019). This relationship hinges on authenticity, empathetic understanding, and reflective awareness (Farber, 2014; Patterson, 1983).

It is important to note that the literature uses several different names interchangeably to describe how this theory is applied to supervision. Initially, Rogers used the term “client-centered” to describe the theory used in counseling (Rogers, 1942; 1957). The term “person-centered” came later as a broader term to describe the principles of this theory and how they can be used in a more general sense (Rogers, 1961; 1969). Patterson (1983) used the phrase “client-centered approach to supervision” while later authors used “client-centered supervision” (Hamilton & Williams, 2007; Lambers, 2000; Raskin, 2007). Some scholars use related terms such as “humanistic-existential” supervision (Farber, 2012; 2014). Although the names differ, the core principles remain the same. Interestingly, Rogers himself did not write extensively about supervision, though he developed the core conditions of the theory (Rogers, 1942; 1957; 1961; 1969). The use of this model in supervision primarily came from later scholars who took Rogers' therapeutic principles and applied them to the supervisory relationship (Hamilton &

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Williams, 2007; Lambers, 2000; Patterson, 1983). For the purpose of this paper, the term “client-centered” will be used to describe the supervision style.

This paper addresses client-centered supervision for the training and development of counselors. While Rogers' core principles have applications across various supervision contexts, this paper focuses on orientation-specific supervision. Although there is limited literature specifically on Rogers' discussion of supervision practices, his foundational principles of empathy, congruence, and unconditional positive regard have been applied to the supervisory relationship (Rogers, 1942; 1957; 1961; 1969).

Major Concepts of the Model

According to Hamilton and Williams (2007), effective client-centered supervision is explained by a five-factor model that includes nondirective collaboration, training in the core conditions, self-evaluation, respect for theoretical diversity, and strong ethical practice. In client-centered supervision, the supervisory relationship is understood as the means to growth, characterized by congruence, empathy, and unconditional positive regard (Hamilton & Williams, 2007). Another core element of client-centered supervision is experiential learning, such as the use of session recordings, process or reflection groups with peers, and other forms of self-evaluation to deepen the supervisee's self-awareness and skill set (Hackney & Goodyear, 1984; Talley & Jones, 2019). Client-centered supervisors often provide supervisees with a structure or system of self-evaluation, aiming to encourage supervisees to identify the skills and knowledge most important to them (Hamilton & Williams, 2007). This reinforces autonomy and reduces reliance on external feedback or judgment. The fifth factor of client-centered supervision is acceptance and respect for other theoretical perspectives. Hamilton and Williams (2007) note that theoretical differences are a natural product of encouraging independent thought and development in supervisees, and that exposure to diverse perspectives can strengthen supervisees' critical thinking. However, in an interview with C. H. Patterson, an expert on the topic, Freeman (1992) notes the importance of the supervisor and supervisee sharing the same theoretical orientation, or at a minimum, having a clear understanding of

the supervisor's theoretical orientation and expectations. In this way, theoretical openness and a clear supervisory foundation work together rather than in opposition.

The client-centered supervisor employs active listening skills and offers constructive feedback with empathy and authenticity to foster growth. A core principle of client-centered supervision is collaboration combined with unconditional positive regard, providing support that balances between passive and directive approaches (Hamilton & Williams, 2007). Ultimately, client-centered supervision fosters a respectful relationship that encourages supervisees' growth while maintaining clear boundaries and purpose. Additionally, the client-centered supervisor's stance highlights the personhood of the supervisee, emphasizing, "the focus is not on the supervisee's personality or problems, but upon his or her relationship with his or her clients" (Patterson, 1997, p. 137).

Within individual supervision, the client-centered supervisor supports a supervisee in developing their skills in a non-judgmental environment. This includes a one-on-one experience with the supervisor in which the supervisor creates a customized supervision session tailored to the supervisee's unique needs. The supervisor facilitates a safe and supportive relationship to promote a neutral, non-directive environment in which the supervisee can enhance their professional skills (Callifronas & Brock, 2017). It is the role of the client-centered supervisor to accept the pace of the supervisee and believe in their ability to develop tools to process through their own challenges (Patterson, 1983). The supervisor functions as a collaborator who supports the supervisee's internal process (Talley & Jones, 2019). The Association for Counselor Education and Supervision (ACES, 2011) practices in supervision guideline 9.b.ii. states, "the supervisor incorporates the supervisee's individualized learning goals for supervision in the evaluation plan," and "the supervisor individualizes supervision based on the specific needs of the supervisee (e.g., learning goals, developmental level, learning style)" (Guideline 11.a.xi.).

Triadic and Group Supervision

Triadic supervision is explained as the process in which two supervisees meet with a supervisor simultaneously (Derrick, 2010; Lyman, 2010). In

2001, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) first allowed triadic supervision but initially limited its use to practicum settings (CACREP, 2001). The 2024 CACREP standards now allow triadic supervision for both practicum and internship settings, requiring that students receive individual and/or triadic supervision on a regular schedule (CACREP, 2024; Section 4). This update reflects the field's recognition of triadic supervision as an effective supervisory format. The Association for Counselor Education and Supervision (ACES, 2011) best practices guidelines prioritize intentional triadic supervision over supervision conducted primarily for efficiency. Therefore, simply being "efficient" cannot be entirely adequate if it does not address each supervisee's needs (Jayne & Purswell, 2017; Lyman, 2010). ACES (2011) guidelines also include how supervisors should facilitate peer feedback effectively and process sensitive issues appropriately. Benefits of triadic supervision include time efficiency, finances, and multiple perspectives. This offers a balanced approach that focuses on attention, peer learning, and diverse perspectives (Goldberg et al., 2012; Lawson et al., 2009). In triadic supervision, client-centered supervisors need to provide both supervisees with equivalent empathy, congruence, and positive regard.

Group supervision refers to a format in which more than two supervisees meet with a supervisor simultaneously (Bernard & Goodyear, 2018). It consists of meeting with a group of students to monitor performance and encourage professional growth (Bernard & Goodyear, 2018). Group supervision is beneficial because supervisees learn from each other through feedback, brainstorming, and exposure to various clinical issues (Borders, 1991; Holloway & Johnston, 1985). Supervisees exchange and receive support in group supervision, which helps them strengthen their capacity for empathetic interaction with clients (Borders, 1991). Client-centered supervision's interpersonal and relational nature makes group supervision well-suited, as it emphasizes the core conditions of the client-centered approach among peers (Callifronas & Brock, 2017). Client-centered group supervision encourages supervisees to grow in compassionate understanding, consistent acceptance of others, and transparent self-expression in the group setting (Callifronas & Brock, 2017; Linton, 2005). Additionally, group supervision creates an ideal environment to foster diverse perspectives and offer feedback (Borders, 1991; Borders et al., 2012).

Both formats, when grounded in the core conditions, offer supervisees a space to learn from one another while experiencing the empathy and unconditional positive regard that define client-centered practice.

Supervisee Learning Style

Client-centered practitioners acknowledge that each individual learns in their own unique way, and it is the role of the supervisor to assess the learning style and developmental needs of the supervisee. Because learning styles differ among supervisees, Bloom's taxonomy is a framework in which supervisors can assess supervisees' learning and developmental levels while in alignment with client-centered supervision (Bloom et al., 1956). Bloom's taxonomy (Bloom et al., 1956) offers a useful framework for understanding supervisee development. It serves as an internal guide for the supervisor's understanding rather than an external structure imposed on the supervisee. The client-centered supervisor trusts the supervisee to identify and pursue their own learning priorities (Hamilton & Williams, 2007).

The supervisory relationship hinges on a developmental evaluation of the supervisee; therefore, it is important that there is a strong bond and sense of safety between the supervisor and supervisee. Client-centered supervisors must reflect on the developmental level of the supervisee (Bloom et al., 1956; Farber, 2012). Stoltenberg and McNeill (2012) noted that supervisees at higher developmental levels were more apt to report a stronger supervisory relationship when compared to supervisees at more novice developmental levels. Broaching and having open dialogue on culture and cultural differences may aid in a strong alliance (Jones et al., 2019). When a supervisee can create a strong and vulnerable supervisory alliance, they are developing the tools to translate the art of relationship building with their clients. The supervisory alliance can act as a guide in which the supervisor models effective communication in a challenging yet supportive way. When there is a strong relationship built, the supervisee is able to develop and learn in a safe and trusting environment.

Feedback and Development

Client-centered supervisors acknowledge and adapt to the learning differences among supervisees, recognizing their individual strengths

and goals. The client-centered-oriented supervisor gives the supervisee ongoing feedback while embodying the core conditions to encourage supervisee growth in self-confidence and development of professional skills (Callifronas & Brock, 2017). Thus, the client-centered-oriented supervisor demonstrates basic respect for the supervisee and their unique learning needs (Patterson, 1983; Bernard & Goodyear, 2018). In accordance with CACREP standard CES.B.2.f, a supervisor must "learn assessment of supervisees' developmental level and other relevant characteristics."

Within the client-centered supervisory model, the working alliance is the foundational driver of development. Morrison and Lent (2018) suggest that a strong supervisory working alliance translates to increased competencies of the supervisee. A strong alliance signals to the supervisee that their supervisor believes in their capabilities (Morrison & Lent, 2018; Lambers, 2000). This, paired with unconditional positive regard, provides supervisees with the safety and security necessary to discuss hardships, areas of weakness, or mistakes within their developing counseling practice. Following the American Counseling Association (ACA) Code of Ethics (2014), supervisors are urged to create meaningful, respectful professional supervisory relationships, in which supervisee and supervisor can provide honest, helpful feedback to encourage and facilitate professional growth (Bernard & Goodyear, 2018).

At times when giving feedback, supervisors must engage in practices that are themselves not client-centered, such as evaluating supervisees' responses and directing critical self-examination (Freeman, 1992). This creates a directive, evaluative stance that contrasts with the nondirective model. Patterson describes this phenomenon as the central tension in client-centered supervision, which is an inherent bind for supervisors (Freeman, 1992). This requires supervisors to balance this tension, knowing when to use evaluative guidance without damaging autonomy or safety (Patterson, 1983; Freeman, 1992).

Navigating this bind well depends in part on how feedback is structured and delivered within the supervisory relationship. Supervisors can provide formative feedback through written and verbal observational skill-based evaluations of the supervisee (Bernard & Goodyear, 2014). Formative feedback is typically informal and ongoing, such as feedback on the supervisees' basic interviewing skills that are

direct or observable. The client-centered model was among the first to introduce electronically recorded interviews and transcripts in supervision (Rogers, 1942). When giving feedback, the supervisor's stance is collaborative, relational, and emphasizes the development of the personhood of the supervisee (Farber, 2012). Summative feedback offers an overall depiction to determine if goals and progress meet the standards and expectations of supervisors (Bernard & Goodyear, 2014). Typically, this form of assessment is more formal and can take place orally or in writing. Rather than a way of doing, the client-centered supervisor would embody a way of being during this process that represents empathy, respect, and genuineness.

Parallel Process and Dual Relationships

Because of the importance of the relationship in client-centered counseling, supervisors are cautious to avoid dual relationships. Dual relationships are typically defined as situations in which one individual takes on multiple roles with another person (Kitchener, 1988). The ACA Code of Ethics (2014) emphasizes the importance of avoiding dual relationships, especially sexual or romantic relationships. In client-centered supervision, supervisors communicate clear boundaries and model healthy boundary setting for supervisees to experience and thereby apply in their own clinical work.

When supervisors respond to supervisees with unconditional positive regard, supervisees internalize these relational patterns and naturally extend them to their work with clients, creating a parallel process (Hamilton & Williams, 2007). This process is not merely observational learning but an experiential integration of the core conditions through the supervisory relationship itself. Even a single supervision session can produce meaningful parallel process effects on the counselor-client relationship (Hamilton & Williams, 2007). The supervisor's consistent demonstration of the core conditions provides supervisees with a modeled experience of how these principles operate in a relationship, which they can then transfer to their clinical work.

Client-centered supervision often embodies a parallel process in which a supervisee's in-session transference is brought into supervision (Arnaud, 2017; Jacobsen, 2007). Jung (1951) argued that a therapist's willingness to engage in their own personal struggles is a marker of their

capacity as a therapist. This willingness fosters growth, learning, and reflection. A supervisee who discusses a client's presenting issue, along with the associated emotional responses, is then able to process that within the supervisory relationship. The supervisor's goal is to create safety, thereby providing the space for the supervisee to process within the relationship (Bernard & Goodyear, 2018; Searles, 1955).

Although parallel processes allow for deeper reflection on interpersonal relationships of supervisee and supervisor, it is important to recognize that this supervision is not therapy. Patterson describes the supervisor as establishing a therapeutic environment, which is distinct from therapy itself (Freeman, 1992). The aim is not to provide therapy to the supervisee but to create conditions that promote professional development through the supervisory relationship (Freeman, 1992). A clear example of parallel process is when a supervisee may be counseling a client on issues of low self-efficacy while also processing low self-efficacy in supervision. Client-centered supervision supports parallel processing and can be particularly beneficial to the supervisee's professional development, fostering increased self-efficacy in their capabilities as a developing counselor.

Novice counselors often enter graduate programs with positive attitudes and hopefulness yet face significant challenges as they encounter the complexity of clinical work during internships (Ikonomopoulos et al., 2016). In a longitudinal study of graduate-level counseling students, Ikonomopoulos et al. (2016) found that despite these challenges, students' perceptions of self-efficacy increased during their program, mainly as a result of their experiences in clinical internships. This is important as this model uses introspection, empathy, and unconditional positive regard to increase supervisee self-efficacy (Hamilton & Williams, 2007; Ikonomopoulos et al., 2016). Within this supervisory approach, supervisees are encouraged to expand their intrapersonal awareness and capacity for growth, processes that can naturally support parallel process dynamics (Bernard & Goodyear, 2018). Although parallel processes may occur, supervisors must have clear roles and boundaries (Talley & Jones, 2019). In addition, it is of the utmost importance to maintain ethical standards within supervision. These elements work together to form a supervisory relationship that centers both the professional growth of the supervisee and the quality of care provided to clients.

Cultural Considerations

When operating from any counseling supervision model, supervisors must strive toward multicultural humility (Hook et al., 2013; Watkins, 2012). Supervisors are responsible for discussing the significance of language by broaching cultural differences to increase cultural awareness (Day-Vines et al., 2007). In client-centered supervision, the supervisor must offer intentional invitations to explore and understand how culture, race, and oppression shape the counseling process, and avoiding these conversations reinforces silence (Douglass, 2007; Hook et al., 2013). Supervisors must attend to cultural differences among supervisees by acknowledging preferred pronouns, preferred name, observed cultural holidays, and not making assumptions about a supervisee's identity. This is congruent with Rogers' basic client-centered principles: supervisees should be looked at as whole individuals and should be considered in the context of their cultures (Day-Vines et al., 2007). Rogers' belief in the wholeness of each person naturally extends to honoring supervisees' full cultural identities (Felder et al., 2021). Therefore, multicultural responsiveness in client-centered supervision is not an add-on competency but an expression of the core conditions themselves.

CACREP (2016) standard CES.B.2.k emphasizes current strategies in clinical supervision. The 2024 revision notably replaces “relevant” with “sustaining” and “clinical” with “counseling,” noting a deeper commitment to cultural responsiveness in supervisory practice (CACREP, 2024; Section 6, Supervision). One such way supervisors apply culturally sustaining strategies is through broaching. In supervision, broaching enables supervisors to acknowledge the relevance of cultural identities and intentionally invite dialogue about these dynamics within the supervisory relationship (Day-Vines et al., 2007). Rather than applying cultural competence as an external skill, client-centered supervisors integrate cultural humility into the relationship itself. Using the core conditions of empathy, congruence, and unconditional positive regard, supervisors enter the supervisee's phenomenological world (Rogers, 1959). This builds a foundation of trust and genuine cultural connection.

Legal and Ethical Matters Related to Supervision

Supervisors discuss many ethical issues, including but not limited to informed consent, confidentiality, legal liability, multicultural competencies, documentation, supervision contract, and protection of the public. Following CACREP (2016) section 6.B.2j, counseling supervisors must follow both ethical and legal guidelines for clinical supervision. Client-centered supervisors oversee supervisees' development using formative and summative assessments discussed above. All professionals within the counseling system are expected to uphold the moral principles of autonomy, beneficence, nonmaleficence, justice, and fidelity (Beauchamp & Childress, 2013). If a supervisee fails to uphold these core ethical principles, it is the supervisor's responsibility to address the breach of ethical principles. Assessment within supervision assists in meeting the legal and ethical needs regardless of the supervision orientation.

Bernard and Goodyear (2014) identified the three major legal issues supervisors may face as malpractice, duty to warn of threat, and direct or vicarious liability of harm. The primary way that client-centered supervisors prevent legal issues from happening is by developing a strong and trusting relationship with the supervisee and having open discussions about these issues. Addressing these issues in supervision lowers the risk of the supervisee withholding information or distrusting the supervisor. Under CACREP standard CES.B.2.i, a supervisor has the responsibility to "learn evaluation, remediation, and gatekeeping in clinical supervision." Hamilton and Williams (2007) encouraged supervisee and supervisor self-evaluations to better ensure ethical practice. By following these guidelines, if a supervisee is at risk of harming the public and causing injustice, it is the supervisor's duty to gatekeep. Without a strong supervisory alliance, supervisees may experience lower self-efficacy, lower likelihood to share mistakes or areas of growth, and lower likelihood to trust the process of supervision.

Limitations

Despite the great benefits of the supervisee-centered nature of client-centered supervision, this structure places heightened responsibility on the supervisees, which can contribute to burnout or potentially lead to insufficient guidance for some. Because client-centered supervision is

driven by the developing counselor, in the early days of practicum and internship, autonomy and self-direction can be overwhelming and lack structure without a seasoned supervisor (Raskin, 2007). Stoltenberg and McNeill's (2012) Integrated Development Model proposes that supervisees, in the early stages of training, benefit from increased structure and direct supervision. Additionally, supervisees who are accustomed to directive, advice-giving roles may struggle to embrace the nondirective stance, creating challenges for supervisors working to maintain the core conditions. Client-centered supervision also requires an institutional climate that respects and supports the approach, as hostile or unsupportive environments can undermine its effectiveness (Hamilton & Williams, 2007).

Client-centered supervision can potentially be more beneficial for advanced supervisees who demonstrate greater self-direction, awareness, and more clinical experience. The effectiveness of this approach also depends on the supervisee's respect for the supervisor, alignment with the client-centered philosophy, and overall relationship fit. Gatekeeping is an essential component of supervision and can be at odds with the nonjudgmental foundation of client-centered supervision. Because of this, supervisors must be able to balance the fundamental aspects of client-centered supervision with a strong ethical framework. In addition, the client-centered supervisor acknowledges power differentials within the relationship and seeks to empower the supervisee. This type of supervision provides a growth-oriented foundation for supervisees. It is best facilitated by supervisors who possess strong ethical judgment and have the awareness and expertise to balance relationships and professional integrity.

Conclusion

This paper provides a comprehensive overview of the client-centered supervision model. It explores how this model shapes central components of the supervisory process, including evaluating supervisees' learning styles and developmental levels, attending to individual differences, and intentionally supporting their ongoing growth and development. In addition, it addresses formative and summative feedback to supervisees, parallel process and dual relationships, and legal and ethical matters related to supervision.

Central to this model is the emphasis on a strong supervisory relationship. This relationship is crucial as it creates a safe space for supervisees to reflect on difficult clinical concepts, engage in self-reflection, and receive feedback. It provides a space to foster self-awareness, insight, and confidence, which positively impacts the quality of care they provide to their clients. In client-centered supervision, a supervisor must model as well as teach the core principles of the approach.

Supervisors model genuine presence, strive to encourage diverse perspectives, and maintain a nonjudgmental stance. The core principles are not only ethically responsible but also drivers of meaningful growth, allowing supervisees to engage on a deeper level with self-reflection, feedback, and professional development. Overall, this supervision model not only addresses and supports supervisee development but also upholds the core values of client-centered counseling practice.

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