CLIENT-CENTERED THERAPY

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Client-centered therapy, also called the person-centered approach, describes Carl R. Rogers' way of working with persons experiencing all types of personal disturbances or problems in living (Rogers, 1959; 1961; 1969; 1970; 1972; 1980a; 1986a). As early as 1939, Rogers developed his theory of psychotherapy with troubled children, and went on to expand his theoretical approach to include work with couples, families, and groups. His most comprehensive theoretical statement was published as a chapter in Sigmund Koch's *Psychology: A Study of a Science (Vol. III)* in 1959, and includes his theory of motivation and personality development, as well as theory of group interaction and interpersonal relationships (Koch, 1959, 184–256). Over his long career, Rogers extrapolated client-centered values to the education, marriage, group encounter, personal power, and conflict resolution (Rogers, 1969, 1970, 1972). Today, the person-centered approach is practiced in the United Kingdom, Germany, France, Greece, Portugal, Demark, Poland, Hungary, The Netherlands, Italy, Japan, Brazil, Mexico, Australia, and South Africa, as well as here in the United States and Canada. A world association, which can be contacted online, was founded in Lisbon in 1997 that reflects the growth and vitality of the approach entitled the World Association for Person-Centered and Experiential Psychotherapy and Counseling (WAPCEPC). Another international organization comprised of a diverse membership—lay persons, educators, business consultants, therapists, artists, psychologists—the Association for the Development of the Person-Centered Approach (ADPCA), is also accessible on the internet.

ROGERS' THEORY OF THERAPY

Based on his experience as a psychotherapist, Rogers postulated that persons possess resources of self-knowledge and self-healing, and that personality change and development are possible if a definable climate of facilitative conditions is present (Rogers, 1957; Rogers, 1980a, p. 115). The implication of Rogers' position is some persons and environments foster growth and development in human beings, and some undermine and inhibit growth. The person's inherent self-directive processes promote greater self-differentiation, more efficient self-regulation, self-understanding, and acceptance (Ryan & Deci, 2000). Rogers utilized the construct of the "actualizing

tendency" to describe the organism's motivation to realize and enhance inherent potentials (Goldstein, 1940; Rogers, 1959; Bozarth & Brodley, 1991).

The therapeutic relationship has been identified repeatedly as a significant part of successful outcome in psychotherapy (Patterson, 1984; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Lambert, Shapiro, & Bergin, 1986; Lambert, 1992; Wampold, 2001). Regardless of therapeutic orientation, therapists who provide Rogers' core conditions at a high level are likely to attain better outcomes than therapists who do not.

THE ACTUALIZING TENDENCY

Rogers' theory of motivation emerged from his observations of clients' growth and development within the therapeutic relationship. The actualizing tendency was a theoretical construct proposed by the great holistic neurologist Kurt Goldstein (Goldstein, 1939; 1940, 1963). Rogers felt that this construct best described the unfolding of human potential he witnessed in his interviews with clients. This construct postulates that all living organisms are continually actualizing their potentials, even under unfavorable circumstances. By way of example, Rogers often illustrated the concept with reference to organisms in the natural world. He wrote about a potato in the root cellar of his boyhood home:

> The actualizing tendency can, of course, be thwarted or warped, but it cannot be destroyed without destroying the organism. I remember that in my boyhood, the bin in which we stored our winter's supply of potatoes was in the basement, several feet below a small window. The conditions were unfavorable, but the potatoes would begin to sprout pale white sprouts, so unlike the healthy green shoots they sent up when planted in the soil in the spring. But these sad, spindly sprouts would grow 2 or 3 feet in length as they reached toward the distant light of the window. The sprouts were in their bizarre, futile growth, a sort of desperate expression of the directional tendency I have been describing. They would never become plants, never mature, never fulfill their real potential. But under the most adverse circumstances, they were striving to become. Life would not give up, even if it could not flourish . . . . This potent constructive tendency is an underlying basis of the person-centered approach (Rogers, 1980, 118–119).

The actualizing tendency functions as an axiom in Rogers' theory. To the extent that the therapist holds the hypothesis that the client possesses the capacity for self-determination he or she is more likely to perceive the client's ideas, feelings, and actions as aspects of growth instead of pathology. It should be stated that the actualizing tendency does not mean that Rogers believed that people are "good," simply that organisms realize their potentials limited only by internal and external environmental constraints (Rogers, 1951, 1959, 1961; Brodley, 1998). Rogers recommended that novice therapists attempt to hold the hypothesis that clients have the inner resources to meet life's difficulties, recognizing that to discard that hypothesis would open the way for the therapist's exerting influence over the supposedly less competent client. This hypothesis, he acknowledged, was most difficult to embrace in the face of self-destructive, self-defeating behavior on the part of the client (Rogers, 1951, pp. 20–25).

The therapist's confidence in the client as the proper architect of the process of therapy—and of his or her life as a whole—logically implies that the therapist need not set goals, give assignments, or direct the process of the relationship. It is this commitment to the agency of the client that is a logical extrapolation from the motivational theory which renders the client-centered approach still radical after all these years.

THE CORE CONDITIONS

For Rogers, the construct of *congruence* refers to a state of wholeness and integration within the therapist. It is a dynamic inner state of being in which the therapist is undistracted by his or her own concerns, and is able to be fully present in the relationship with the client (Baldwin, 1987; Bozarth, 1998; Brodley, 1998). Congruence is a distinctive inner experience as opposed to a behavior, although behavior or communication that issues from the congruent therapist may be labeled "congruent." Congruence is theorized to emerge from the therapist's self-acceptance and positive self-regard (Bozarth, 1998), and from the evolving capacity for self-awareness free from inner censorship (Brodley, In press). A congruent therapist spontaneously conveys to the client the qualities of genuineness and transparency—a willingness to be known. It does not imply self-disclosure, a behavior with which it has been erroneously equated. The client rightly feels him- or herself to be in the presence of a person, not someone enacting a professional role. In fact, while the client-centered therapist *is* a person, he or she is engaging in a practical art and discipline of empathic understanding of the frame of reference of the client. This conscious, disciplined devotion to providing the core conditions in the service of the client may be understood as the enactment of a kind of expertise and as the application of a technique, but to stress this aspect of the practice misses its fundamental character. Peter Schmid describes the practice in the following:

> Person-centered psychotherapy is the practice of an image of the human being which understands the human being as a person and thus encounters him or her personally acknowledging him or her as the Other . . . instead of objectifying him or her by trying to know him or her, to get knowledge over him or her (Schmid, 2001, p. 42).

The essence of client-centered therapy is a relationship between two sovereign human persons in which the therapist's skilled "performance" requires being oneself! It involves the complexity of reflexive awareness of one's being-in-relation with oneself and the client—as Schmid has put it, being an expert at not being an expert.

The second condition is described as the therapist's experience of prizing, nonjudgmental caring, or *unconditional positive regard* toward the client, the client's beliefs, ideas, behaviors, or ways of being. Unconditional positive regard, as Rogers pointed out, is a condition that exists upon a continuum; we are sometimes conditional in our regard for the client, but strive to realize greater and greater acceptance in the relationship. Effective therapy, Rogers asserted, probably would not occur to any significant degree if the therapist were to experience consistently negative feelings or attitudes toward the client. Therapists who are trying to develop themselves in the

client-centered approach may first be committed in principle to realizing the condition of unconditional positive regard. The therapist's conscious value as it is lived out with clients gradually leads to spontaneous feelings of warm caring and acceptance of the client, even in the face of beliefs and behavior which the therapist might deplore in other contexts. It is to allow oneself to leave one's ordinary discriminating, dualistic mindset behind in the service of meeting another person and his or her world of meanings.

The third condition is the therapist's experience of *empathic understanding of the client's frame of reference*. Rogers eloquently described this condition in his book *A Way of Being*:

> The way of being with another person which is termed empathic has several facets. It means entering the private, perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in the other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening (Rogers, 1980, p. 142).

Importantly, Rogers did not specify how these core conditions or facilitative attitudes were to be expressed in the therapeutic relationship. Rogers' empathic understanding of the response process (Temaner, 1977) that has been caricatured as merely parroting back—a simplistic technique of "active listening"—was, in fact, a discovery and innovation of great consequence. Shlien asserted that the empathic response (also called "mirroring" or "reflection") had been "unfairly damned" in that it has been portrayed by many as a behavioral technique. Shlien felt that this form of response uttered by the experienced client-centered therapist could be artful and seamless (Rogers, 1986).

There is a crucial distinction between the therapist who instructs him- or herself to repeat back the words of the client *in order to convey to the client that the therapist empathizes and understands,* and the therapist who responds empathically in order to check his or her understanding for him- or herself. In the first case, the therapist has an aim *in addition* to understanding the communication of the client. He or she wishes to imply "You are making sense; I understand what you are saying; I am empathic with you." The second therapist has *no other goals* in the moment other than to grasp the meanings being expressed by the client. The client's experience of being understood by the therapist is a *by-product* of a therapist's sincere effort to grasp the meanings of the client's narrative and his or her relation to his utterances and to express those meanings so as to check their accuracy. You might say that the first therapist, while trying to express understanding of what the client has been saying, is at the same time trying to "spin" his or her response to *achieve a particular effect* in the client. Client-centered therapists, having no goals for clients, also seek no "effects." But, you might ask, if there are no effects, where is the therapy? We would that client-centered therapy, indeed, does have powerful effects, but those effects are the by-products of a relational process that consciously and deliberately strives to minimize influence upon or power over the client (Witty, 2005). Clearly, no therapy is free of influence (Masson, 1988, 1994; Pentony, 1981; Proctor, 2002), but we would maintain that the disciplined attempt to preserve the client's freedom and safety in the therapy relationship creates

a distinctive relationship which empowers. The principle which guides the therapist in realizing this relation is that of nondirectiveness.

THE NONDIRECTIVE ATTITUDE

Client-centered therapy is unique in its commitment to principled nondirectiveness (Grant, 1990; Bozarth, 2002; Brodley, 1997; Witty, 2004). The foundation of client-centered practice rests not on method but rather on the therapist's respect for and personal openness to the client as a sovereign being of inexhaustible depth and meaning (Rogers, 1961; Schmid, 2001)

If a therapist directs the client to discuss contents that the therapist believes to be focal to the process, the therapy is not client-centered. If the therapist orchestrates the ways in which clients relate to their concerns or to how they express those concerns, the therapy is process-directive and not client-centered. In this respect, client-centered therapy stands alone within the family of person-centered and humanistic therapies.

In an interview with Michelle Baldwin in 1985, Rogers asserted that the only goals therapists should have are goals for themselves. What he meant was that the only acceptable goals in client-centered therapy relate to the therapist's ability to realize the therapeutic attitudes of congruence, unconditional positive regard, and empathic understanding of the internal frame of reference of the client (Baldwin, 1987).

Rogers' theory of the necessary and sufficient conditions, however, was intended to describe *any type* of therapeutic relation, without regard to therapeutic orientation of the therapist. It is sometimes referred to as the "'integrative' statement of the necessary and sufficient conditions" (Bozarth, 1996a, b). Client-centered therapists do try to realize the attitudinal conditions in their relations to clients; however, they do so from a particular valuational stance of respect for the self-realizing capacities and right to self-determination of their clients. Rogers particularly appreciated Nat Raskin's description of the non-directive attitude which he cited in *Client-Centered Therapy* published in 1951:

> There is [another] level of nondirective counselor response which to the writer represents *the* nondirective attitude. In a sense, it is a goal rather than one which is actually practiced by counselors. But, in the experience of some, it is a highly attainable goal, which . . . changes the nature of the counseling process in a radical way. At this level, counselor participation becomes an active experiencing with the client of the feelings to which he gives expression, the counselor makes a maximum effort to get under the skin of the person with whom he is communicating, he tries to get *within* and to live the attitudes expressed instead of observing them, to catch every nuance of their changing nature; in a word, to absorb himself completely in the attitudes of the other. And in struggling to do this, there is simply no room for any other type of counselor activity or attitude; if he is attempting to live the attitudes of the other, he cannot be diagnosing them, he cannot be thinking of making the process go faster. Because he is another, and not the client, the understanding is not spontaneous but must be acquired, and this through the most intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention (Rogers, 1951, p. 29; Raskin, 1947, unpublished manuscript).

Although Rogers did not stress this fundamental attitude in his later writings, he endorsed this stance consistently throughout his long career (Brody, 1991, Brodley

and Brody, 1990). Rogers states that in crisis situations or client emergency, even more commitment to a non-directive expression of the attitudes is needed rather than the assertion of the therapist's authority:

> When the situation is most difficult, that's when a client-centered approach is most needed and . . . what is needed there is a deepening of the [therapeutic attitudes] and not trying something more technique-oriented (Rogers & Russell, 2002, p. 258).

Client-centered therapists make a strong distinction between therapies that are, at heart, didactic and therapies that emphasize understanding and valuing the client's personal attitudes, agency, and experiencing. We do not disagree that clients' ideas, beliefs about the world, and themselves are sometimes irrational or distorted. We place our faith in the relationship conditions as a fertile medium in which clients' views of self, others, and the world gradually change in the direction of greater acceptance and greater endorsement of consensual reality. We believe if therapy is a teaching relation—even the most benign and supportive relation—it reinscribes the model of power *over* the client; it reiterates the subordination of client as a receptacle of knowledge from the more powerful and expert figure in authority, the therapist. We would rather express through the consistent, deep attention to grasping the internal frame of reference of the client through empathic understanding, our profound valuing of the subjective reality of the client, including clients who are burdened with disturbances in thinking and emotion. We believe that honoring the client in this way, meeting the client as a whole person, ultimately empowers the person. We observe in the course of client-centered therapy that clients become more authoritative in describing their experiences, in asserting their own ideas, beliefs, and feelings, and in choosing paths of their own forging. This results in greater personal stability and self confidence.

ROGERS' THEORY OF CHANGE

Rogers' presented his theory of the necessary and sufficient conditions for psychotherapeutic personality change in 1957. This seminal contribution to psychotherapy theory has led to scores of studies over the past forty-odd years that have robustly supported the significance of empathy, warmth, and genuineness as aspects of the therapist's presence related to positive outcome in therapy (Patterson, 1984). More recent work by Asay and Lambert supports Rogers' necessary and sufficient conditions. Their research estimates that approximately 30% of the variance in outcome can be attributed to "common factors" which includes the relationship, with 40% relating to client factors such as social learning, health, etc., 15% relating to specific techniques, and 15% reflecting expectancy or hope for the success of therapy (Asay and Lambert, 1999, pp. 23–55). Whether it is described as a "therapeutic alliance" characterized as tasks, bonds, and goals, or more broadly as a relationship, we can be sure that the conditions provided by a caring, genuine therapist who is attempting to understand are pivotal in terms of facilitating therapeutic personality change. Less well acknowledged is the critical role of the client as a "common factor" who actively engages in the relationship, collaborates in the tasks of therapy, and focuses a variety of resources on personal healing and positive change (Tallman & Bohart, 1999).

EXAMPLES OF CLIENT-INITIATED HOMEWORK

In my practice of client-centered therapy which commenced in 1974, approximately 15% of my clients have initiated homework assignments for themselves in the context of client-centered therapy. Other client-centered therapists who were asked to estimate the percentage of clients who initiate homework have responded with roughly the same percentages. In this section of this chapter I will provide two examples of this self-initiated work by clients. I have selected examples that stand out in my memory due to their distinctiveness or creativity.

"Lourdes"

Lourdes is a 48-year-old woman who emigrated to the U.S. from Honduras upon her marriage to Mark, an American businessman. Her move to the U.S. occurred approximately 20 years ago. Shortly after coming here, Lourdes was accepted to a Master's program to prepare her for work in the Latino/a community here in the U.S. as a counselor.

One of the consequences of her marriage necessitated leaving her aging, widowed mother in Honduras. Because Lourdes is an only child, her leaving for the U.S. left no other family members to care for her mother, although her mother resides with another family in a small apartment attached to their larger home. Her relationship with her mother had been strained and conflicted since puberty when her mother referred to her as a "bad girl" who would become a prostitute unless her mother intervened to prevent it.

In the beginning of therapy, Lourdes expressed gratitude for her mother's efforts at keeping her from a life of dissolution and sin. After a year of therapy, Lourdes began to see her mother's behavior in terms of its profound lack of acceptance of her, and in terms of the emotional violence that had been done to her as a young teenage girl. This was a turning point in the therapy. Lourdes wept bitterly about this inexplicable loss of her mother's love—a love which turned to contempt for her. Convulsed with sobbing in therapy, she said "She stabbed my heart!" For many years, Lourdes had tried in vain to win her mother's love back; she sent money to Honduras every month. She visited loaded with presents. She called every Sunday. Within the therapy, she finally began to accept her mother's hateful, hurtful behavior. She asked me to help her understand her mother's attitudes and behavior. Over time, we pieced together a kind of provisional interpretation of her mother's punitive attitudes which drew from our understanding of religious views of women and sexuality; the conservative attitudes toward women's place and role in Latin America; and, more specifically, her mother's own unhappy relationships with men. This work was necessary because Lourdes did not want to conclude that her mother was a bad, unfeeling person, nor did she want to conclude that there was anything wrong with her behavior during the years her mother had been so punishing.

Lourdes posed to me the question of how she could manage to stay in relation without being continually wounded. She requested my help in devising ways for her to gradually wean herself from this abusive and pain-filled relationship, with the hope that her mother might come to a different understanding of Lourdes as a human being. Over the years, this client requested that I listen to letters she had

written to her mother and to comment on them mainly in order that Lourdes not wound her mother in return for all the wounds inflicted in the past. I was asked to help Lourdes prepare for conversations over the phone to help her limit contact if her mother became judgmental. She asked me to review what she had decided she would and would not tolerate on her visits to Honduras. She became capable of limiting her phone calls if her mother started to criticize Lourdes or her husband, and on one trip to Honduras, she actually left a restaurant where she and her mother had gone for a luncheon when her mother insulted her. She had entered a period in which she was not going to take any more abuse. This approach (enacted over a period of 10 years or so) has led to a more harmonious relationship in which her mother has actually begun to express gratitude to her daughter and to praise her many accomplishments. But Lourdes has left her mother behind psychologically and so while she appreciates the positive words, it is too late for her to go back to any real intimacy. Lourdes deeply regrets but accepts this outcome. She has said "My relationship with my mother is what it is, and so be it! It is a great sadness for both of us that she could not accept me as a person!"

Another turning point occurred when she announced that she wanted to work on her own moral development. She had been reading literature about various moral exemplars such as Gandhi and Father Oscar Romero, as well as writers who presented a spiritual vision of human life, including Krishnamurti, and she had become very involved in her own church community. She wanted to work consciously and deliberately on becoming a compassionate, principled person. She enlisted my help in generating tasks that would support this life-long commitment. An example of this occurred recently which may illustrate how these collaborations happen.

Lourdes is a highly intelligent, very attractive, and powerful woman. She has matured and gained confidence in her effectiveness as a counselor, and has taken initiative to educate other helping professionals about Latino a cultures in consultative workshops. As she has worked in community agencies, she has often been supervised by younger, Caucasian men whose knowledge and experience and awareness of Latino culture are no match for her own. She has negotiated these relationships with trepidation, because she does not want to dumb down her own competence and knowledge as a counselor, nor does she want to have conflict with her supervisors.

Lourdes recently requested my help with finding what she terms a "way of compassion" in dealing with the latest of her supervisors who is threatened by her and who is openly hostile to her in agency meetings. First, she asked my opinion about whether I regarded this supervisor's behavior as hostile. With the proviso that I was going on her information only, and obviously had no access to his motivation, I answered tentatively that what she described did indeed seem hostile to me without knowing whether or not he was intending hostility or whether he was even aware of what he had said. She then tried to imagine his vulnerability as a much younger, less experienced supervisor having to deal with someone older, a woman of another race and ethnicity, who had much more experience. In our conversation, we explored the dilemma she faced. Should she behave more deferentially to him? Should she "stroke" his ego in the ways she saw other female counselors doing? Or, should she refuse to treat him as a little boy——which is how she perceived others treating him—and instead express her true feelings, reactions, and thoughts which had already had the effect of evoking his hostility?

Lourdes expressed the following: "I want to treat him in accordance with my principles—to be compassionate. I also do not want to lose this job; I love the job

here. I wonder how to find the way to do both. This is a challenge to my moral development." She asked my opinion which I gave, as I believe in answering clients' questions if I feel that I have an answer of my own to offer. I expressed my belief that colluding with the other staff who were not openly expressing their reactions seemed disrespectful to this supervisor. I also expressed the possibility that if Lourdes took the route of passive compliance, she would feel disappointed in herself and that it would disrupt her personal harmony with herself. She agreed with this and said that she would need to find a way to communicate non-violently in this situation. We spontaneously role-played some responses she might want to make which met the requirements of honesty and respectfulness. She also said that she would increase her meditative practice to enable her to have the necessary self-control to engage with her supervisor non-defensively and from a stance of sincerity and appreciation for him as a person who is doing the best he can. After deciding to go on retreat to have time to meditate, she ended the session saying, "I believe that there are dark forces which may work through us, and my job is to shed light on those dark forces of my own. In that way I can shed more light on him and be open and caring toward him." She explained, "It's not so much of what I say to him or how I say it. It's a matter of transforming my own consciousness in the direction of acceptance."

This example describes an unusual therapy relationship. First, the length of time we have worked together is now approaching 14 years. This has not been continual but with some breaks of several months. She has continued to request more therapy saying that talking with me helps her feel happier with herself because she is more able to live out her values if she expresses what those values are and has the opportunity to map out ways of behaving more consistently.

Second, Lourdes is a client who solicits my reactions, ideas, and views in virtually every session. It is perhaps hard to understand how a non-directive client-centered therapist can justify acceding to these requests because clearly my responses and answers may be highly influential. Although some might say they are directive, I would argue that one's *intention* to be non-directive makes a crucial difference in how clients receive my responses to their requests. When I have asked her directly about the possibility of her taking what may well be flawed counsel from me, she has stated a number of times "Don't worry! I do what I decide is best; I wouldn't do something just because you believe it is a good idea!" Client-centered therapists are not eager to express their thoughts and opinions; there is a willingness to do so when asked, because it accords with a stance of principled non-directiveness (Grant, 1990).

"Harry"

Harry entered therapy in the midst of an emotionally devastating breakup of a long-term relationship. His partner had pushed a note across the kitchen table one morning that said that she was leaving that morning with the dog to move in with a younger man. The fact that both Harry and his partner had been involved in mentoring this younger man at the university at which they both worked made the injury even more painful, as Harry had to face that he had been betrayed by two persons he cares deeply about.

The breakup precipitated a crisis for my client. He acknowledged that for years he had been afflicted with depression, panic attacks, and agoraphobia, and, as a consequence, had come to depend on his partner for almost everything. He could not bring himself to go into a grocery store, do laundry, or travel freely anywhere in the

large metropolitan area in which they lived. He understood that this overwhelming dependency had perhaps been gratifying to the partner in the early years of the relationship, but had become more and more burdensome to her as the years passed. His agoraphobia was so intense that a close friend accompanied him to sessions at my office for the first several weeks after the breakup.

At the urging of his family, Harry requested a referral to a psychiatrist for medication. He was prescribed an SSRI, which succeeded in diminishing his overwhelming sense of hopelessness and doom. He gradually became capable of attending our sessions unaccompanied, and I became aware of both his high intelligence and talent, and the depth of his impairment. After several months of weekly sessions, he told me that he had decided to try to work on his agoraphobia so as to enlarge his world and his repertoire of behaviors. He knew that he would either have to make it on his own or return to the small town of his childhood where his family could look after him. He felt that to return to his childhood home would be the end of his life as an adult, independent person.

At this time, Harry's "circle of safety" was small, and he followed the same route to and from work every day. Fortunately, his workplace was an environment in which he was respected and supported. His supervisor had allowed him to take some time off at the worst of the crisis. In the next several weeks he announced that he had located a group for agoraphobics meeting in a church. He attended the group doggedly even though he found it difficult to get there and he was openly skeptical at times about some of the other members and their plans for recovery. However, the normalizing effects of being with other persons who were afflicted with panic disorder and agoraphobia were apparent. He was not alone in this struggle.

Over the next year, he set more goals for himself, to enter a grocery store, to stay alone in his apartment, to travel by himself in his car on a 5 hour road trip to see his mother. All of these initiatives were his own and have gradually led to improvement and a greater sense of personal power. But there were many times where he failed to achieve the goal of shopping or going to an unfamiliar destination. In therapy sessions he would berate himself as a "loser". His despondency was profound. But he has pressed on and has continued to set more goals for himself. He has had difficulty knowing when to allow himself to take a break from the discipline of facing his fears, given that non-agoraphobics may often allow themselves the freedom to decline a challenge.

The point of this case summary is that clients in client-centered therapy sometimes set personal goals and make progress toward fulfilling those goals without any direction by the therapist. We cannot identify with certainty the causal variables involved in his movement toward recovery. Very probably, the therapy, the medication, familial support, support from friends, and his own character were influential in his gradual improvement. It also must be said that the client is not "cured" in any total sense. He still has to overcome inner resistance to traveling to new places and dealing with interpersonal relationships where there is conflict.

MEANS AND ENDS IN THERAPY

In 1970, Tomlinson and Whitney argued that therapeutic outcome criteria necessarily reflect values that practitioners of particular therapy orientations endorse.

This is to say that even the most "objective" statements regarding "good adjustment" are rooted in the theorist's picture of an ideal—of maturation, human development, health, wholeness and the like:

> Therapists typically believe that they know what kind of client behavior is desirable, and though they may not actively strive to develop such behavior, they still evaluate their own efficacy in terms of the degree to which they can observe the presence of that behavior in the client's emergent self . . . . Thus the measure of outcome must be in terms of what the therapist and his (sic) theory designate as the ideal man (sic), and these considerations are rooted in values, not in objective considerations of adjustment (Tomlinson & Whitney, 1970, pp. 454–455).

The aims of client-centered therapy include strengthening the personal authority of the client as a knower and reliable creator of personal meanings, beliefs, ideas, and whose own inner experiencing can be trusted as a guide for living. Clients in client-centered therapy become more self-assertive, more confident in their own frames of reference, more capable of risk-taking, more open to experiencing, more empathic toward others (Rogers, 1961). These valued ways of being seem to result from the lived value of non-directiveness, which results in a profound respect for the client and for the client's own choices and self-direction. They further argue that the aims of client-centered therapy are consistent with its method.

Within this particular therapeutic paradigm, it should be clear that assigning homework, making interpretations, attempts to influence the client, or any number of "interventions" must be considered contradictory to the aim of trusting the client's own experience as a trustworthy guide. There is one condition, however, under which this contradiction can be avoided; that would be a *request from the client* for homework from the therapist. Most non-directive client-centered therapists are open to questions from clients and do their best to respond with real answers if they have them (contrary to the frequent caricature of the approach as interminably repeating back what the client has said!). So a request for a homework assignment from a client would be accepted and would be responded to with respect for the client's inquiry. The only limit would be the therapist's personal knowledge base in terms of whether or not she or he could recommend a particular homework assignment or set of assignments as potentially helpful in meeting the client's stated aims.

CLIENT-INITIATED EXPERIMENTS
AND HOMEWORK

Because client-centered therapists are willing to answer clients' questions, if clients want concrete suggestions or help with attitudes, beliefs, or problem behaviors, the therapist is open to offering help that he or she deems relevant to the request or to refer the client for adjunctive experiences, education, or other therapy. Had Harry asked specifically for resources that would help him overcome the agoraphobia, I would have readily referred him to a colleague of mine who works from a Cognitive Behavioral framework with problems of panic and agoraphobia. Many clients in client-centered therapy have sought out adjunctive experiences to aid them in reaching personal goals. Included in this list are practices to aid in the management of stress, various types of meditative practice, yoga, more frequent attendance at church, the

use of daily affirmations in the context of 12 Step programs, and therapeutic massage. Some clients who are struggling with weight and eating problems and clients with addictions to substances have joined groups such as Overeaters Anonymous, a group dedicated to Fat Acceptance (National Association for Fat Acceptance), structured cognitive behavioral approaches to control bulimia, harm reduction approaches to addiction, and all of the 12 Step programs. Clients have taken up journaling and art therapy to cope with early childhood trauma. A client who was questioning his gender identity utilized his high level of computer expertise to transpose his male face onto female bodies and female faces onto his own scanned image of his male body. The deep acceptance of the therapist seems to allow the client to share these experiments with little fear of not being understood or judged. Because of the therapist's attitude of acceptance of the client whether or not he carries through with proposed experiments, resistance and methods to get the client on task are never an issue. The client does not have to anticipate being remonstrated or even questioned by the therapist about plans she discussed the week before. She is likely in that environment to discuss the fact that she did not follow through and the reasons for aborting the mission.

Barbara Brodley, a master therapist and strong proponent of the client-centered approach in the U.S., provides a session excerpt of one of her clients who initiated homework in order to deal with alcohol use which had become a danger to his life and his marriage (Brodley, in press):

Client: I've got to admit it, I get drunk and I'm a bastard to her. I've scared the kids. (Pause 10 seconds.) I've got to stop drinking, I'm out of control and I'm killing myself.

Therapist: Mhm, hmm. It's not only hurting your marriage, your children. You're killing yourself. You're risking your life.

Client: Yeah, I'm really in danger (pause) and dangerous (pause). I need something besides this [he gestures, referring to the relationship]. I believe I'll cut down or stop, while we're talking. (T: Mhm, hmm) But I lose resolve after a few days. Tension builds up, I start drinking and I'm out of control.

Therapist: (Mhm, hmm) Talking like this isn't enough to hold you. You loose control.

Client: Right. (Pause.) I got off cocaine. I stopped killing myself that way. But now I've gotta put some brakes on the drinking! (Pause) I think I need a group, maybe AA, to support me between sessions.

Therapist: Uhmmm. You need other people who are in this *with you* more than I can be; others who can support you getting control.

Client: Yeah. I really do. (Pause) I should make some calls for an AA group. (Pause) I'm not sure it'll work for me 'cause I don't like their religion part. (Pause) I guess I'll do that. I'll do that before I see you next.

Therapist: Mhm, hmm. You've got reservations, and you're not sure it'll help (pause) but you want to try it at least. (C: Yeah) And you want to get to it right away because you feel really desperate. (C: Yeah)

Brodley comments, "The client continues about the risks he takes and his remorse. He starts the next session spontaneously reporting on the action he has taken to get a group."

Client: I called AA groups, but the one closest to me isn't open to new people now. A couple others were closed or too far away. Anyway, I'm doing something more than talking about it and that's better.

Therapist: Mhm, hmm. It didn't work out yet, but you're doing something, not just talking. (Pause) That feels better.

Client: Yeah. (Pause) I don't know if it'll help, but I want to keep trying until I find one I can get into.

Brodley continues,

In the quoted dialogue, I responded empathically and offered no explicit support, guidance, or approval for the client's plan or for having done what he said he was going to do, or for his intention to continue. Subsequently, the client did join an AA group, got a sponsor and stopped imbibing alcohol while continuing in therapy. His depression and the angry outbursts diminished. He reported that he felt less reactive to annoyances, more tolerant of his children's misbehaviors and petty differences with his wife. Discontinuing his use of alcohol also improved his sleep, his sexual potency and he thought it helped him be more attuned to his wife's needs (Brodley, In press).

Advocates of homework might argue that these gains could have been achieved more quickly with direct assignments, and that the gains might have been more thorough going, but this raises the fundamental question regarding the impact of therapist-initiated projects or goals for clients.

As previously cited, Tomlinson and Whitney argued cogently that means and ends must be consistent within any approach to working with clients. Recognizing that intervention strategies vary in terms degrees of intrusiveness, client-centered practitioners who embrace a non-directive attitude oppose therapists' directing either the process and/or content of therapy. This is because of the belief that the "means" are, in fact, "ends" at a lower level; if the ultimate goal of all therapies is to foster a person who is more autonomous, more free, and more capable of deciding which goals are worthy of pursuit, then the therapy needs to align itself as a practice which is consistent with these goals.

From this point of view, goals set for clients, in the service of which homework assignments are given, may foster dependency at worst or may undermine the client's self-esteem and confidence in his or her own ability to generate meanings and behavior that is more adaptive. For example, asking another person a question has a demand characteristic in that it is difficult not to respond with an answer without violating social norms. But in answering, the client is complying with the therapist. While the therapist's intention may be completely benevolent, the client's experience in answering probably includes an element of compliance.

The evidence for the efficacy of homework has been demonstrated in the work of Kazantzis and Deane (1999). We do not take issue with this claim, given the goals served by the homework: reduction in stress, reduction in anxious or depressed mood, etc. Three categories were identified as not strongly addressed or enhanced by homework; these included "sexual abuse," "learning disorders," and "delusions and hallucinations" (Kazantzis & Deane, 1999, p. 583). From the standpoint of means–ends consistency, homework would appear to be a helpful adjunct to goals of symptom reduction. It is far from clear, however, that unique goals which clients formulate in the course of client-centered therapy such as "a more meaningful life," "living more compassionately," or "restoring dignity" are necessarily enhanced by *therapist-assigned* homework. Some clients may elect to set a course of work or experiments for themselves in the service of precisely such overarching aims: meditation on the suffering of others, taking up a Great Books course, or some other enhancing practice.

Even if we were willing to classify these client-initiated experiments as "homework," they still differ significantly from the homework described in the literature reviewed by Kazantzis and Deane (1999). In these studies, homework related logically to a symptom behavior and was designed by the therapist who tried to achieve high rates of client "compliance" with the assigned work through exploring how confident the client was that he or she would complete the assignment and whether there were any obvious barriers to completion. Even under the best of circumstances with a very benevolent and respectful therapist, the homework is a therapist-initiated intervention in which a client's lack of cooperation may lead the therapist to interpret the "resistance" or to blame the client for faulty motivation. In order to fairly assess comparative outcomes between these cognitive behavioral approaches and non-directive client-centered therapy, there would need to be attention to the discrepancies in what a "good outcome" constitutes, and importantly, who decides when that "good outcome" has been achieved.

SUMMARY

There is no doubt about the efficacy of well-formulated homework assignments in the context of reducing problem behavior (Kazantzis & Deane, 1999). The position of non-directive client-centered therapists critiques the practice in terms of the ethical constraints of nondirectiveness which posit respect for the other person as paramount as opposed to the attainment of behavior change or any other goals not articulated and sought by the client. In the broadest sense certainly some kind of change must occur in order to justify doing therapy, but client-centered therapists place trust in the client as the person who decides whether or not the kind of change produced by psychotherapy is worth the inevitable injuries to self involved in even the most sensitive and carefully nondirective relations.

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