3 CLIENT-CENTERED THERAPY WITH DAVID: A SOJOURN IN LONELINESS

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HOW I CAME TO WORK WITH DAVID

In 1987, about six years into my doctoral program in counseling psychology at Northwestern University, one of the persons I was interviewing for my dissertation introduced me to a friend of hers whose son had been diagnosed with a severe mental illness. This woman's wish was simply for her son to have some contact with people. She did not have unreasonable expectations from the therapy. She asked me to see David, who was about 28 years old. I agreed and set up an appointment to see him at my office.

Instead of showing up at the scheduled time, David arrived about four hours late, saying that he had been "walking around Chicago." Realizing that regular appointments wouldn't work, I volunteered to see him at his home because I was still attending classes and his family's home was on my way. For about a year, I saw him weekly at his home, each of us seated at the kitchen table. I asked his mother to remind him the night before of my arrival time the next day. Often when I arrived, David would come out to meet me as I drove up. Occasionally, he would comment on how much more of my back seat had been torn apart since my last visit by my beloved German shepherd (ironically named *Patience*).

I have a particularly vivid memory of one of the early sessions in which David's dysfluency was pronounced. As each syllable spun around in my short-term memory, I awaited the next bit and the next, finally resulting in a sentence I could not comprehend. At the end of that taxing session, David took my hand and said with complete fluency, "Thank you for your patience." Because I had not been sure up to that point that he had much awareness of me, I was surprised and touched by his expression of gratitude. From that point on, I was "all in."

David then and today is a person of character and creativity. He paints and has written poetry in both English and Spanish. In the time we worked together, he didn't blame others; he didn't express self-pity or complain about his situation of unrelenting loneliness. What he wanted—and continues to want—is understanding and respect. David also wishes to share his life with others and to enjoy camaraderie with them as can be seen in the following therapy session.

After about a year of our working together, David's parents found a community in Hawaii that provided a haven for persons with severe mental illness. It was near the beach and had a community garden. David agreed to try it, and he ended up spending two years in that program. When it closed, he began working with a social worker in Hawaii who looked out for him and kept in touch with his family. Before he left for this community, I requested permission to tape our two last sessions. Both David and his mother gave permission.

As I undertook this case study, I recontacted them and received permission for this project to use case notes and the transcript of one of the sessions. In the process of contacting them, his mother told me that she had published a book in collaboration with David. From this source I learned about David's life after he left Chicago and was able to read some of his writing.

A CLIENT-CENTERED POSITION ON CASE FORMULATION

Case Studies in Psychotherapy illustrates approaches to conceptualizing clients and the therapeutic methods advocated by the major theoretical orientations. The majority of orientations regard initial and ongoing case conceptualization as essential to the appropriate identification of treatment goals and interventions that are believed to lead to successful outcomes. An outcome may be defined in terms of achievement of insight, the reduction of problematic behaviors or symptoms, compliance with medication and therapy, better scores on objective test measures, higher levels of social adjustment, improved social skills, trauma-management skills, better quality of life, becoming a fully functioning person, and so on. Whether bio-, psycho- or sociogenic causal factors are stressed, case formulation is mostly considered essential to guiding the therapy process. The hegemonic influence of the *medical model*[1] is ubiquitous in the education of counselors, social workers, and psychologists, who learn to view diagnosis as necessary to justify the selection of specific, effective "treatments."

In contrast to the medical model (see Elkins, 2007; Wampold, 2001), the dominant paradigm in clinical psychology—the client-centered vision of the person as a self-determining and self-righting agent—is heretical. Conceptualizations may range from feminist psychology's political analyses of the impacts of social class; disability; ageism; sexism; homo-, bi-, and transphobia; and racism to cognitive behavioral theories' identification of irrational core beliefs, psychodynamic theories' explication of disorders of self and attachment, trauma psychology's elaboration of the impact of varieties of trauma, and biological theories of genetically influenced vulnerabilities. I recently consulted with a therapist about his transgender client and presented a nonpathological understanding of this difference in gender-identity development. At the end of the consultation, he commented, "There *must* be some form of trauma at the root of this!"

It's very hard to pry a therapist away from a unitary theory of causation. All of these formulations share the same essentialist assumption about psychopathology located in the microcosm of the individual soma or psyche, or in the societal macrocosm, or the two in combination. Exceptions to the essentialist assumptions undergirding the medical model are found in the various humanistic theories as well as systems, social constructivist, and narrative or collaborative approaches (Anderson & Gehart, 2006; McNamee & Gergen, 1992).

[1]The medical model in psychotherapy is a descriptive schema borrowed from the practice of medicine and superimposed on the practice of psychotherapy. The schema—including its assumptions and terminology—accurately describes the processes and procedures of medical practice and has been highly useful in that field. However, the schema does not accurately describe the processes and procedures of psychotherapy and is problematic when superimposed on that field. In medicine, a *doctor* diagnoses *a patient* on the basis of *symptoms* and administers *treatment* designed to *cure* the patient's *illness*. In psychotherapy, medical model adherents *say* that a doctor diagnoses a patient on the basis of symptoms and administers treatment designed to *cure* the patient's illness. However, when practitioners make this claim, they are superimposing a medical schema on psychotherapy and using medical terms to describe what is essentially an interpersonal process that has almost nothing to do with medicine (Elkins, 2007).

A UNIVERSAL THEORY OF PSYCHOLOGICAL MALADJUSTMENT

Carl R. Rogers's definitive theoretical statement (1959) provides us with a theory of therapy and personality, an account of infant development, a motivational theory based in organismic theory, and a theory of interpersonal relationships. Rogers's theory posits that psychological maladjustment results from incongruence between a person's concept of self and her organismic experiencing. A client-centered therapy relationship restores the client's congruence through experiencing self in the context of the therapist's unconditional regard. Rogers's theory of therapy does not function based on specific diagnoses because his theory of human maladjustment is universally applicable and his therapy offers the same facilitative therapeutic conditions for all persons and all sorts of problems. His theoretical formulation is situated at the universal level of analysis, not at the level of group categorizations. At the same time, Rogers foregrounds the client's phenomenology—reality as uniquely perceived—at the level of analysis where "I am like no other person."

Rogers's theory of psychological maladjustment asserts that persons often suffer with "conditions of worth" (Rogers, 1959, p. 204). This concept simply refers to the child's having internalized attributions about his or her embodied self from parents, teachers, peers, and others who assert that he is "bad," "selfish," "stupid," "ugly," "worthless," "a sissy," or "lazy" and "a coward." These judgments shape the child's picture of him- or herself. Rogers posits that the human being, like any living organism, is an ongoing process of organismic valuing. Picture an infant who tastes peas for the first time and spits them all over himself and his highchair while shaking his head in disgust as if to say, "No peas! No mas!" Organismic valuing refers to "an ongoing process in which values are never fixed or rigid, but experiences are being accurately symbolized and continually and freshly valued in terms of the satisfactions organismically experienced . . . " (Rogers, 1959, p. 210). As we mature, this process becomes more available to awareness and to direct expression in language, but the process is theorized to precede the acquisition of language.

In particular, an infant or child's aggressive behavior, or what is interpreted as "disrespectful" behavior, evokes strong, often punitive conditions of worth; eventually these pleasurable experiences or honest expressions go underground and are ejected from the child's conscious experiencing. When a child's self-concept begins to contradict the flow of organismic experiencing, there is a significant increase in tension, anxiety, and vulnerability that Rogers defines as *incongruence*. Tension between a child's inherent organismic valuing process (righteously hating those who scold and devalue her) and her self-concept (I am a loving child!) leads to distortions in self-perception and inaccurate self-representation. Increasingly, the child denies to awareness all manner of authentic experiences, including those in which she excels or exhibits positive aspects of self. An apt description for this condition is that of having been *colonized* and *alienated* from the truth of one's physical, emotional, and cognitive being.

CLIENT-CENTERED THERAPY RESTORES THE SELF TO CONGRUENCE

While "problem-centered" approaches enjoin the client to identify his or her problems, to set treatment goals, and comply with treatments, the client-centered therapist provides the client an empathic and accepting psychological climate characterized by freedom and safety. In this interpersonal environment, the client can allow herself a wider aperture of experiencing, which often begins with reiterating the introjected attributions

composing the self. When, most surprisingly, the therapist does not counter these excoriating self-judgments, the client is free to reconsider their accuracy from within this novel context of acceptance and respect.

In client-centered therapy, the overarching goal is to be of help to the client, however that help is ultimately construed. Beyond this metagoal, the therapist's goals are for herself: to realize her commitment to experience and to implement the therapeutic attitudes outlined in Rogers's theory of therapy (1951, 1957, 1959) and to remain in all ways consistent with the ethical principle of respect for the client and the client's freedom. This stance of principled nondirectiveness (see Grant, 1990) is fundamental to client-centered practice.

Rogers identifies the therapist's congruence as a sine qua non of the process of therapy. If the client does not perceive the honesty and genuineness of the therapist, then she will not be able to believe her perceptions of the therapeutic conditions of empathic understanding and unconditional positive regard. *Congruence* refers to the therapist's genuineness—entering the relationship transparently as oneself without the usual professional façade. It refers to a willingness to be known and to not deceive the client. The therapist aims to empathically understand the client's communications, to respect the person's autonomy throughout the process of therapy, and to prize and accept the client as one who is doing the best he or she can. These therapist-experienced conditions, in concert with the client's inherent motivation to actualize organismic potentials, are viewed as the change-inducing variables. In this environment of freedom and safety, the client determines her own process and content within each session and from week to week over the course of therapy, also determining when she is ready to end the therapy relationship.

Because the therapist is committed to the self-definition and self-determination of the client as an ethical stance, he need not attempt to persuade or reframe or guide the client. He need not press the client to take psychotropic medications or be hospitalized. Occasionally, the client may ask directly for the therapist's thinking on a particular issue. Principled nondirectiveness is logically consistent with the desire to respond honestly to the client's requests and questions. If the therapist has ideas or can accommodate the request, then he may offer a response and check in with the client regarding the helpfulness of the response, and the therapist will be particularly interested in whether his response showed an accurate understanding of what the client was seeking.

You might ask, "But what about the client who continually wants direction and who seemingly wants to remain dependent on the therapist?" Client-centered therapists accept the person where he or she is, without judgments about "immaturity" or applying diagnostic labels such as "dependent personality disorder." If we can ethically meet clients' requests or answer questions or provide various types of accommodations, then our inclination is to accept these requests at face value. We assume that the dependent behavior of the client will most often give way to greater levels of self-regulation when the dependency is not punished or judged to be unacceptable. As Ehrbar comments, "Paradoxically the intent to instill an internal locus of evaluation in the client is directive and is thus inconsistent with client-centered therapy . . . !" (Proctor & Napier, 2004, p.157). Client-centered therapists also acknowledge that there are many resources for growth and support and find it congenial to work in tandem with other therapists or providers should the client wish to experiment with other sources of support.

A CLIENT-CENTERED VIEW OF POWER AND AUTHORITY

As early as 1942, Rogers addressed the issue of whether or not a therapeutic relationship is compatible with authority. He states, "It seems to the writer that the counselor cannot maintain a counseling relationship with the client and at the same time have authority

over him. Therapy and authority cannot be coexistent in the same relationship" (Rogers, 1942). One may object that inequality between the client and therapist is inherent by virtue of the structure of one person seeking help from another (Brodley, 2011a; Proctor, 2002). Because of this structural inequality, client-centered therapists attempt to share power and to relinquish power as much as we can. We almost never insist on terms of formal address such as "Doctor," although some clients persist in referring to us with such terms. We also try to identify the sources of expertise involved in answering questions when such expertise is sought. The idea is to make the process of arriving at answers or opinions transparent to the client and to share our rationale along with the logic undergirding our answers to clients' questions.

As the therapeutic attitudes are perceived by the client over time, Rogers hypothesizes that change will occur in fairly predictable directions (Rogers, 1961). Clients usually experience greater self-comprehensibility, self-acceptance, self-authority, and openness to their own and others' experiences. They become more skilled at making decisions and choices that align with their own organismic valuing process. Clients tend to move toward greater compassion and generosity toward others as their own needs and wants are asserted and recognized and satisfied in the process of living. Clients take more risks in order to fulfill the inner guidance of the organism as opposed to conforming to outside demands; in fact, clients in client-centered therapy experience deeper, increasingly existential living (Rogers, 1961).

Rogers's therapy is a *psychological* therapy meaning that the domain of the work is the client's relation to herself being in the-world and being with others. In this respect, the client-centered therapist does not take on responsibility for diagnosing and treating "illnesses" such as eating disorders, depression, panic disorder, PTSD, and the like. Rogers rejected diagnosis as a precondition for therapy (Rogers, 1957; Shlien, 2003). When meeting a client for the first time, he did not want to see the client's previous psychiatric or psychological records, wishing instead to encounter the client without preconceived ideas or diagnoses. Because he believed that the client's perceptions of reality were what counted, clinical assessments were unimportant and irrelevant. He made clear that client-centered practice would not change because the client was diagnosed with a particular disorder or was a "homosexual" or was developmentally disabled or belonged to any other group. Rogers would not have endorsed the idea that our therapy changes according to the client's gender, social class, or race. The therapeutic attitudes do not change in character, although the therapist's *attunement to the individual* may lead to unique and nonsystematic expressions and accommodations. Serendipitously, this attunement promotes the client's understanding of the therapist's communication and intentions. An example of this attunement is my experience with a client whose voice was so soft that I sat on the floor fairly close to her feet in order to hear. I had decided that, given her vulnerability, I did not want to request that she speak louder. There are many examples of these attunements to the client so as to implement the therapeutic attitudes.

ROGERS'S POSITION ON DIAGNOSIS

In his book *Client-Centered Therapy* (1951), Rogers argues from a paper he presented at Harvard in 1948 in which he warned that the shift of the locus of evaluation from the person to the clinician leads to dependency on the presumed expert who is going to apply the curative "treatment." Presciently, he expresses a deep concern about the implications of diagnosis as leading to control of the many by the few.

> One cannot take responsibility for evaluating a person's abilities, motives, conflicts, needs; for evaluating the adjustment he is capable of achieving, the degree of reorganization he should undergo, the conflicts which he should resolve, the degree of

dependence which he should develop upon the therapist, and the goals of therapy, without a significant degree of control over the individual being an inevitable accompaniment. As this process is extended to more and more persons, as it is for example to thousands of veterans, it means a subtle control of persons and their values and goals by a group which has selected itself to do the controlling. The fact that it is a subtle and well-intentioned control makes it only less likely that people will realize what they are accepting. . . . If the hypothesis of the first trend proves to be most adequately supported by the evidence, if it proves to be true that the individual has relatively little capacity for self-evaluation and self-direction, and that the primary evaluation function must lie with the expert, then it would appear that the long range direction in which we are moving will find expression in some type of complete social control. The management of the lives of the many by the self-selected few would appear to be the natural consequence. If, on the other hand, the second hypothesis should be more adequately supported by the facts, if, as we think, the locus of responsible evaluation may be left with the individual, then we would have a psychology of personality and of therapy which leads in the direction of democracy, a psychology which would gradually redefine democracy in deeper and more basic terms. We would have a place for the professional worker in human relations, not as an evaluator of the self, behavior, needs and goals, but as the expert in providing the conditions under which the self-direction of both the individual and the group can take place. The expert would have the skill in facilitating the independent growth of the person (Rogers, 1951, pp. 224–225).

Rogers's psychological therapy involves encountering the client on her own terms, and trying to see the world from her perspective. As Brodley has stated, the only reality relevant to the person's development and healing is reality as perceived by the client herself. In this sense, within the context of therapy, the theory of personality and motivation as formulated by Carl R. Rogers (1959) is as irrelevant as any other biopsychosocial or psychiatric theory! In other words, the therapist is not aiming at convincing the client that he possesses an actualizing tendency or even that his experiences are worthy of respect. In the grand gamble regarding success or failure in therapy, Rogers puts his bets on the client's actual experiencing of the core conditions as a path to a more nuanced, self-differentiating, accepting, and authoritative experience of the organism—hence, a more congruent self.

THE NONDIRECTIVE ATTITUDE

Raskin's description of the nondirective attitude describes what is involved in this approach.

> There is [another] level of nondirective counselor response which to the writer represents *the* nondirective attitude . . . 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 make 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 (Raskin, 1947/2005; Rogers, 1951, p. 29).

Meeting the client on her own ground, giving full attention to the exclusion of any other intention to formulate or diagnose, and experiencing the attitudes of unconditional positive regard and empathic understanding of the client's frame of reference are the only appropriate goals for therapist (Baldwin, 1987). Rogers's therapy is exemplary as a profoundly egalitarian and mutual relational conversation.

Although, in fact, Rogers's sessions contain a high percentage of empathic understanding responses, client-centered practice in its totality over time takes many forms. It is first and foremost a living human relationship in which the therapist offers help (however that may come to be defined); as in any relationship, issues crop up and are addressed. Questions about the therapist are sometimes raised—questions about racial identity, relationship status, sexual orientation, political beliefs, educational degrees, social class, parental status, and so on. The client will only pose these questions if she has not been discouraged or punished for asking—as occurs, for example, when the therapist comments "Well, this therapy is about you and your concerns; not about me." On our side, the therapist may ask questions for clarification; make statements from our own frames of reference; make spontaneous personal expressions of joy, dismay, and sympathy; and sometimes volunteer opinions even when they are not strictly solicited by the client. The practice with each client is, by definition, unique to this pairing. The therapist also has personal boundaries and personal requirements that she may occasionally need to disclose to her clients and that become part of the collaboration. "Please do not wear any scented products or perfumes since I am susceptible to migraine!" "Please leave your firearm in your car when you come to sessions because guns make me nervous." "Yes, you can bring the baby. Let's see how it goes." "Sure, I'll remind you that you wanted to continue to discuss the problem with your husband next week when we meet," and so forth. As a client-centered therapist's practice matures and deepens, we enjoy psychological freedom and spontaneity within an ethical position of nondirectiveness.

CONSISTENCY BETWEEN MEANS AND ENDS

I have frequently heard the view that claims that people who grew up in collectivist, traditional cultures that venerate authority within the family, in the civic sphere, and in religion and politics will not be able to function well in the egalitarian atmosphere of client-centered therapy and that they require more directive approaches.

This contention illustrates a misunderstanding of the principle of nondirectiveness as if the client-centered therapist will reject being perceived as an authority, scold the client for any display of dependency or requests for help, and criticize the client's traditional attitudes—for example, seeing women as inferior to men. On the one hand, if the therapist accepts and embodies the authority position, then he simply reinscribes hierarchical structures of power, using unethical means for an ethical end (Brodley, 2011a; Levitt, 2005; Proctor, 2002; Witty, 2005). On the other, an attempt to "enlighten" the client as to the superiority of egalitarianism contradicts the principle of respect for the client. The answer to persons who are living within such traditional structures and hierarchies is neither to engage them from a stance of expertise and authority nor to attempt to "liberate" them but rather to meet them as one person to another, accepting their inclination and need to elevate and idealize the therapist and to credit our utterances with a great deal of meaning and authority.

If we believe that the process of therapeutic change is a natural response to the therapeutic conditions in concert with the person's own potentials for growth, then in the long run the client's own self-authority is likely to emerge. Her emergent "voice" may bring her into conflict with her family and culture or it may not, but from our point of view there is no ethically acceptable alternative to providing a nondirective moral space that inevitably empowers the person. Maureen O'Hara, who has compared the emancipatory educational project of Paolo Freire with Rogers's views on therapeutic change, states:

> It is a profound contradiction for a liberational educator, community worker, humanistic therapist or workshop convenor to use techniques that, even momentarily, rely on the domination or objectification of another. . . . Freire (1970) decries revolutionary leaders or educators who "massify" the oppressed, practicing manipulation and indoctrination behind some rationalization:
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> > In fact, manipulation and conquest, as expressions of cultural invasion, are never means for liberation. They are always means of "domestication." True humanism, which serves human beings cannot accept manipulation under any name whatsoever (Freire, 1970, p. 114 cited in O'Hara, 2006, pp. 120–121).

THE THERAPY SESSION

The following verbatim transcript is one of our last sessions before David left for a program for persons with severe mental illness in Hawaii where he was to live for the next six years. David has read and had the opportunity to edit this document, and he has given permission to use this material for publication.

It is important to understand that I had already met with David numerous times prior to this session because the central theme of this session echoes many earlier sessions yet may sound as though I am hearing about these events for the first time. I experienced these sessions as being called on to witness a calamity that had unjustly been visited on an innocent person. As a therapist, one is always a witness to the life and suffering of the client, but in David's case, this implicit stance emerged as the central and fundamental truth of our relationship. I felt that implicitly David called me to believe and bear witness to the fact that he has been deceived, tormented, insulted, violated, and humiliated by voices. He calls my attention to the fact that he has been taken away by the police, pushed into ambulances, and hospitalized and medicated against his will since the voices began.

Note: The client (C) is David; the therapist (T) is Marge.

C1: Well, the first thing I want to talk about is that I woke up today early—and I'm not—I didn't stay up because I knew I was going to hear the voices, and I didn't see any reason to, you know, make any—uh—great effort. But I did feel good when I woke up, and I—uhm—did get up, and I would have *stayed* up if I hadn't thought I would hear the voices.

T1: So then what you did was—did you go back to bed? [A tracking response asking for clarification].

C2: Yeah.

T2: 'Cause you did start hearing the voices?

C3: Yeah, and this is one of the main things that the voices criticize is that I'm lazy. I'm saying that for the benefit of the tape! [short laugh].

T3: Mm hm, right [short laugh].

C4: And uhm. . . .

T4: But it's funny because in a way one of the reasons that you're so-called lazy is you get tormented by the voices!

In this response, I interrupted David and made a comment from my own frame of reference, a supportive interpretation that illustrated both my momentary loss of neutrality and desire to defend him from the voices' accusation of laziness. I regard this as a "spontaneous" response but one that, if practiced systematically, would constitute an error of attitude, meaning that I would have slipped into the mistaken practice of trying to influence my client's own self-evaluation in a more exculpatory, self-acceptant direction instead of attempting to understand his expressive communications. In contrast to "reframing" the client's cognitions and evaluations, client-centered therapists try to understand and accept even the most excoriating self-assessments, respecting the client's right to be his own source of evaluation.

C5: Well, yeah, I either stay up all night or I am so disoriented when I fall asleep that I guess I have to admit that I usually miss when the sun comes up. Uhm—I'm—I'm—uh—t—ti—tired of waking up late.

T5: It's frustrating to have your routine disrupted so much so that you can't seem to get on a regular schedule. Is that your point?

A better, more accurate response here would have been simply "You're tired of waking up late." Client-centered therapists consider the "target of empathic understanding" to be the intentional communication of the client, both the narrative content and the person's implicit relation to the narrative or the "point." In this response, I erred a bit on the general side, deriving a point from what was implied rather than staying with his exact expression. Even when the client accepts a response—which David does here and, as in this case, it is wide of the mark—it is incumbent on the therapist to listen to her own response with an eye to its accuracy.

C6: Yeah, and it's my problem. And like I said, I think that's the main thing that the voices and other people are critical of. They think it's some kind of fault, but all that I have to say about it is that it says on my birth certificate that I was born at 11 o'clock in the morning, so if I was born at 11 why shouldn't I just sleep till 11?

T6: Mm hm.

C7: And I know it's kinda stupid to believe that when you're born has any significance, but I feel that it's a comfortable thing to wake up late, and I've proven in the past that I'm capable of getting up in the morning, but that happens in situations where there is some *reason* to get up.

T7: Mm hm, where there's something that you want to do or go some place you want to go.

C8: I had a hard time getting up at Gould's farm, but . . . but, I mean, Gould's farm was a complete, uhm, shambles. I mean, that uh—the voices were—were—were happening the whole time.

T8: Mm hm.

C9: Uh—I—I—think I've shown pretty well in my life—not overall—but pretty well, that when there's something to do, or the situation is pleasant, or somehow you're coming off of—uhm—some kind of uh—pa—passage, that I—I can wake up at, but uhm, I—I'm—I'm not sure. I think that the voices, especially the ones on the TV, because those are, you know, more real, you know, I think there's no question that they're threatening me.

T9: Mm hm. I wanted to uh check with you. Does this machinery bother you at all? The tape recorder? I mean, does it feel like you're hearing anything from it? Cause I didn't want . . .

C10: No, I don't think I've ever been taped before.

T10: Uh huh, just let me know if it bothers you.

David's reference to the voices on the TV that were threatening him caused me immediate concern regarding whether he was being bothered by the tape recorder. Mostly I had not taped our sessions, so I wanted to know immediately if it was bothering him, although in my checking this out with him, I missed an opportunity for an empathic response.

C11: Yeah.
T11: But anyway.
C12: I can't remember being taped before.
T12: Yeah, well, let me know, but your point is that for some reason the voices that you hear over the TV are more real, and they're more threatening. Is that right then?

Client-centered therapists' responses are deliberately tentative in tone, even when the declarative form is used. This tentativeness signals to the client that I am not privy to his meanings and must make an effort to get it right. If I don't, I want to be corrected. As clients settle into the relationship and trust the therapist (perhaps in part because of this careful effort), they become much freer to spontaneously correct the therapist's errors of accurate understanding.

C13: Um—uh—uhm—uhm—placable as it seems, you know, that—that—this is—this is—really, you know, something that see—that seems to be happening.
T13: Mm hm. I made a mistake. In other words, you didn't say that they're more threatening but that you feel that they're threatening *you*.
C14: I could have sworn they said something to that effect last night. And it didn't uh—uh—didn't go very well with my—you know—functioning.
T14: Mm hm.
C15: It is destructive, and I don't know why it's necessary. I mean, there's no, no . . .
T15: It's destructive to your functioning.

Client-centered therapists make a practice of openly acknowledging mistakes in empathic understanding when they occur as I do in T13. This practice is a natural outgrowth of respect for the client as an equal participant in the conversation. As this transparency persists over time, by sharing how one arrived at an answer to a question or the logic and reasoning behind a tentative interpretation, the client develops a tacit or explicit understanding that the therapist's goal is to understand the client's communications, not to improve, correct, or educate. It is also important to note that David is aware of the destructive impact of the voices. Many persons categorized or labeled as "psychotic" or "schizophrenic" are believed to have little or no insight into their own "illness" or their situation in general. Here David is expressing his opinion that the effects on him are destructive and unnecessary.

C16: There's no question that—that you know I have certain needs. I like to have a cigarette when I wake up in the morning, but if I wasn't hearing the voices, I don't think I would have turned into a chain smoker. I—I—I know that the voices are using some of my ideas against me, and I don't think that's very good. And . . .
T16: It's like you're explaining to me that these voices really screw you up in a lot of ways, right? Because you smoke more, and it interrupts your sleeping habits, right? And it really makes it hard for you.

In this response the opening phrase "It's like you're explaining to me . . . " is an example of my reflecting the client's agency or intentionality in this moment. This practice contrasts with the simplistic instruction to listen for "feelings." Although occasionally clients use explicit feeling words, probably most often they are "describing," "explaining," "regretting," "wondering how . . . ," "frustrated by," and so on. By reducing these expressions to simple feeling words, the therapist substitutes "round" terms for precise

meanings expressed by the client. In David's next sentence, for example, he is asserting a descriptive truth of his experience with the voices.

C17: Yeah, well, I mean, both of them are chauvinists, there's no question about that.
T17: And what does that mean?

This question for clarification was understandable but probably a mistake; I should have simply reiterated his term and allowed him to clarify if he wished to do so. In working with clients who have various kinds of expressive difficulties (including those who must work with a therapist who doesn't share their mother tongue, children, and those with articulation problems) the therapist must balance her desire for a high degree of understanding with the desire to free the client to give his narrative unimpeded. It is frustrating to be constantly stopped and asked to clarify small points of meaning, so in work with clients whose expressions may be ambiguous, I sometimes prefer to let the ambiguity stand in order to respect the client's own rhythm and pace of expression.

C18: Well, they're—very bu—bullish, you know.
T18: Did you mean like macho?
C19: Yeah.
T19: Mm hm.
C20: So.
T20: Unpleasant, very unpleasant, and kind of dictatorial.

As stated previously, this clarification of the meaning of the word *chauvinists* risked pushing David off of track.

C21: Yeah. They—they—they—just—you know—kind of—I don't know—ruined the basic struggle that I was going through. And they just kind of—ruin—ruined it when I think I was—when I think I was going to make a turn anyway.

From the beginning of the session, David gives more and more evidence of the interference from the voices as he attempts to get his sleep schedule going and other attempts at organizing himself in terms of when he awakens and begins his day. He goes on to clarify the hostile and undermining quality of the voices and now, asserts the disastrous effects they have "when I was going to make a turn anyway." He describes this calamity that he experienced and continues to experience and how it commenced years before.

T21: Not sure if I follow you. Do you mean that you were going along in your life, struggling with various things, and then when the voices came into your life, they ruined that?
C22: Well, it's just that I think I was—I was at a point, you know—when I was—when the voices first happened, that I was getting a better orientation, and really, you know, that was—that was significant enough because I was—whatever would have happened without the voices would have been significant enough because Lords house [residential care home] is is a real—uh, you know, funky place. I mean, not that it's dirty or anything, but it—it—it—um, it's just uhm, got a kind of a very uh—un—uh—mo—un—pa—un—un—un—pa—very—un—un—functioning group of people. That's—that's about the size of it, and most of the people don't do anything, you know. And that . . .
T22: It's upsetting to be around a lot of people who are just kind of doing nothing.

Although my response captured the last parts of David's statements, I missed the most important point, which was his assertion that he had been in the process of "getting a better orientation" when the voices first started, and that that was significant.

C23: So, it's—it's a spa—special type of uhm, situation which is just very weird you know, because it doesn't fit in with the neighborhood. The neighborhood is mostly Spanish. And it—it do—doesn't fit in with the other elements of like, uhm, middle class and stuff.

T23: So it's like you felt kind of out of place there, I mean because Lords House didn't fit in.

In this response, as I look at it now, I think that even though David did not explicitly state that he felt out of place, I gave myself the license to make an empathic guess as to why it was important to him regarding the fact that the residential care home itself did not "fit in with the neighborhood." This represents the focus on the client's relation to his narrative content. I follow and teach this instruction in doing this form of therapy the principle of trying to understand the client's "point."

C24: Yeah.

T24: Didn't fit in.

C25: Is that this? [David gestures toward my right.]

T25: I don't know. Oh! It's the radiator—I bet—that you're hearing, yeah.

C26: Oh. See I'm—I'm drp—I'm pretty sure that there was one day when—when the voices had kept me up all night and that day I think was the day when the voices became uh—uh—a real uh—mess, you know? And uh, came across in a very su—s-s-s-ertive way.

T26: A very assertive way?

C27: Yeah.

T27: Now, this is three years ago? [Actually, it occurred probably around nine years earlier.]

C28: Yeah.

T28: I see. In other words, you're talking about the point at which it seemed like the voices really created a mess in your life?

In this response, I extrapolate from his earlier statement in C26 "and that day I think was the day when the voices became uh—uh—a real uh—mess, you know?" saying "it seemed like the voices really created a mess in your life." This changes his meaning from the "voices became a real mess" to "the voices really created a mess in your life." My response is an error of accuracy. This is a common mistake I have long observed in teaching client-centered therapy, so it is humbling to find myself making it here. In this category of "mistake," students stay close to the stated expression but actually extrapolate a meaning that weaves the individual bits together so as to give them more sense instead of sticking with a statement that they actually don't understand. I think it is much better to stay with the client in hopes that he will elaborate his statement or spontaneously clarify it. If the client fails to do so, then the therapist may ask for clarification. The intent of this practice is not to be pedantic or persnickety or obsessively detailed. The intention is one of respect. This entails not speaking for the client, not putting words in the client's mouth. Making the client's ambiguous statements less ambiguous is an unintentionally paternalistic behavior. It misrepresents to the client a clarity he does not yet have in his expression and risks confusing or misleading him about what he was trying to express. To state that you didn't follow or in some cases restate verbatim what you do not understand empowers the client by giving him the opportunity to clarify his statement and perhaps elaborate further on his point. As Nat Raskin pointed out, it is faithful to the principle of the client as an architect of both the content and process of the therapy (Raskin, 1988). In these small ways, the client-centered therapist's moment-to-moment practice embodies an attitude of principled nondirectiveness (see Grant, 1990).

C29: Well, they started on their kind of uhm—bas—basic—uhm—buh—ba—brain thing. They—they seemed to have some kind of kind of motive or plan, and that's when they sort of started. And it all has to do with trying to gain my trust at first, and then revealing that—that uhm—kind of uh—special uh, knowledge that they had about—about—about my past. So—so I guess, you know, they tried to get my trust at first, and they succeeded and then—then—uh, then after the weekend was over, I went on this big walk around Chicago. And I mean if the voices had been a normal experience, just a sort of a temporary you know, thing, then the voices would have stopped after I went on that walk around Chicago. Uhm, you know, it would have just been one weekend which was weird, but—but they didn't stop. And when I got back, then—then—uh—it—uhm—continued.

This series of statements is given with a heaviness and sense of fatalism and of remembering something very painful.

T29: In a way it's like what you're describing is that somehow they got your trust in the beginning.

C30: Yeah.

T30: And then they turned on you, right? By revealing special knowledge about your past.

C31: Yes, yeah.

T31: So the feeling is one if you were kind of conned or betrayed.

C32: Yeah, that—that they kind of exci—excited—these kind of potentials in my mind, and I guess the reason I trusted them was because I—felt that I—I was—uhm—uhm—pretty powerful myself.

T32: You mean at that time in your life you felt powerful yourself, so they didn't seem threatening to you at that point so you could afford to trust them.

C33: Right, I—I—what I was saying was that I—I had a day in between this night when I stayed up all—all night. I had a day in between and I got up early on the day when this started . . . Oh, God . . . (Pause) . . . I mean, that's what—that's what I think. Because after I stayed up all night, I went to sleep, and I'm pretty sure that I slept. Because the day on Saturday when the whole thing came about—uhm—uhm—that was a full day, and that—that uh—that's my belief anyway—is that I had a good night's sleep, and I woke up early and I was just kind of, might say, innocent at that point.

David's utterance of "Oh, God" was one of the most emotional statements he made in this session.

T33: Not sure I follow the sequence, are you saying that you stayed up through a whole night . . .

C34: Yeah, listening to the voices, I sat in a chair.

T34: And then you went to bed the next day and slept pretty well. And then you woke up and . . .

C35: And I had that day in between, which is you know, just your basic day.

T35: Where you didn't hear them?

C36: Not really, no.

T36: And then they came back?

C37: Yeah. That's what I think because—because I—I am sure I have the time orientation to some extent.

T37: At least well, you're trying to remember things that happened several years ago.

C38: Yeah.

T38: Right, and you're trying to tell me what how it came on.

C39: Yeah, what—see—I don't think that I would have accepted the voices so openly if it hadn't seemed like a natural occurrence upon waking up, whereas really, the other night I stayed up all night and didn't go to sleep until the morning, so . . .
T39: I guess I understand this point that you mentioned that when you woke up, you felt kind of innocent, or I guess just open.
C40: Right.
T40: Right. And then you started hearing the voices, and it seemed kind of benign, like well, you could afford to trust them, or it wasn't anything problematic at that point, so you're describing to me how you came to take them in, right, or "allow" them in.
C41: Right.
T41: Mm hm.

David is taking pains to describe the sequence of events that occurred years past that led to the "invasion" of the voices. He comments that he wouldn't have "accepted the voices so openly" had they not been coincident with his waking up. His narrative in this session makes clear that the voices are a "mess," and that they ruined his functioning and that they are "destructive." I have no inclination to counter David's reality, to reframe his experience as the "onset of illness," or persuade him that the voices should be viewed as unworthy of his attention. As with any other client, I take David's account at face value within the context of the therapy session.

Do I think he "has" schizophrenia or some psychotic thought disorder? Does he experience "auditory hallucinations?" These questions about diagnoses and symptoms are irrelevant to our conversation. Within humanistic psychology as a whole, intense debates between the advocates of biological causation and diagnoses and those who reject the discourse of disease reflect resistance to the current hegemony of the psychiatric establishment and its pharmaceutical sponsors. However, the debate has no bearing on who I am with David and what I am ethically committed to in my relationship with him (Sanders, 2007; van Blarikom, 2006). This stance is not taken to avoid involvement and place the burden on the families of the person with "mental illness" (although that is most often where it falls in our society). My point is that within the context of my therapy relationship with the client, my ethic is solely one of obligation and responsibility to my client. In extreme circumstances, I may decide to intervene, which would constitute a necessarily paternalistic response. Such interventions that are driven by obligation to the professional code of ethics cannot be automatically justified as in the client's best interests. When parents of other clients with a diagnosis of severe "mental illness" have implored me to pressure the client to either take medication or go into the hospital, I have reiterated the significance of the client having one person who will be committed to her only. To join the coalition between the psychiatrist and the parents and family members would mean that the client no longer can trust me to respect her own choices and not take power over her.

C42: And the problem is that nobody else seemed to notice it, except this guy, Perry.
T42: Nobody seemed to notice what, that . . .

My own implicit belief that the voices were internal to David is exposed here in that I completely fail to understand his statement. Understandably, if I heard a voice I didn't recognize, I would ask someone near me if they also heard it.

C43: The voices.
T43: Uh huh.
C44: Kenny might have noticed them, but I mean what can you say about Kenny, he's just kind of a real creep.
T44: Alright, these people that were living with you then at Lords?
C45: Yeah.
T45: I see. And you think that they might have also heard what you were hearing.

C46: Yeah. But uhm—uhm—uhm—I think not nearly to the extent that I was. Uhm—uh, because you know they, I tried to explain that th—this is you know—a ver—fault of—falling—fa—falling into a kind of a—you know, uhm—dream reality, uhm, but the problem is it's *real*, and you see, my parents believe that it's schizophrenia, and the psychiatrist believes that it's schizophrenia, and uh, I guess my sisters believe that it's schizophrenia, but I have no question that it's real.

To me, this is a remarkably lucid description. David's experience has been one of "falling into a kind of dream reality, but the problem is it's *real*," and *no one believes his assertion*. Instead, he is urged to translate his experience into "consensual reality," which does not feel true. He isn't sick or "schizophrenic"—he is being intruded upon, shamed, and threatened. These psychologically meaningful experiences do not correspond to David's understanding of "illness." I can understand why he is affronted by others' assertions about his "schizophrenia" in that his ability to articulate what has happened is fully intact. His ability to argue from his own perception of reality is fully engaged and clear. His assessment of the impact of the voices is reasonable and coherent.

One might argue that all of the typical signs of "severe mental illness" that David reports—hearing voices who have hostile intent, feeling that his privacy has been invaded, that he is threatened by the radio and TV, that his own thoughts are somehow being broadcast against his will—are, if deliberately depathologized, common experiences in our culture. I also wish to avoid "normalizing" his experiences as merely a form of "distress," which I believe euphemizes the severity and catastrophic nature of his condition. I have no doubt that David's life has been one of almost constant affliction, the etiology of which is still contested and caused by many factors in combination. Regarding the relevance of the question of etiology, however, Lisbeth Sommerbeck, a Danish psychotherapist who has worked exclusively within the psychiatric context, states:

> As already stated, psychiatric diagnosis is of no issue in client-centered theory and therapy. The conditions necessary and sufficient for facilitation of the client's most constructive potentials are trusted to be the same for everybody, irrespective of diagnosis. Or seen from another angle: the act of (psychiatric) diagnosing would imply that the therapist is in the position of the expert, he *(sic)* would view the client from his (the therapist's) own frame of reference, the locus of evaluation would be in the therapist, and it would be the therapist, not the client, who knew what was wrong with the client. All this has nothing to do with client-centered therapy; it belongs to the medical model, not to the client-centered model (Sommerbeck, 2003, p. 33).

T46: Do you mean that it's upsetting to have all these people around you in your life, your parents, your sisters . . .
C47: Yeah.
T47: Dr. So-and-so—
C48: See there's been a big change. My parents are being quite sympathetic now, but uh—uhm—th—this is—this is because they both believe that I—I have also shown some some uhm, truth or r—reason and so [doorbell rings]. . . . Well, I guess you have the door.
T48: Yes, that's probably (. . .). I interrupted you, David, you were, I guess, I don't know. Where were you?
C49: Something about my parents . . .
T49: Being sympathetic?
C50: Right.
T50: Because something about that you found some truth or . . .

C51: Well, I really couldn't dream these explanations up by myself. I would have had to be experiencing something to come up with these things that I try to explain. Uh, I think that's the main thing.

T51: So it's like you feel like you have more credibility.

C52: Well, they're on my side, you know, and that's not always been the case that they have uhm—given—given—m—me—uhm—you know the uh—the—well, for example, last night, this girl left her checkbook in a taxi and the driver came to the front door to return it and I didn't want to let him in because he was wearing a jacket that looked like a policeman, you know, and I have ridden in police cars and ambulances and stuff quite a few times and . . .

T52: So it scared you.

C53: Right. But see, that's the main thing, though, my parents have not tolerated uhm—ba—bad behavior on my part. They have called or they have taken me to the hospital, and uhm—in—in that sense, you know, this "whooya tooya" business and stuff and it is really facetious because I I have—uhm—been uh—uhm—tolerated by my parents uh only after I have been hospitalized thirty times. So that proves you see that we have gone along with the uhm—system, and for the voices, and I especially mean the voices on the TV and on the radio and on the street, to say "whooya tooya." I don't think they have the right to do that because my parents have not patted me on the back and you know, expressed their love, you know, they have taken dramatic steps, you know, to get—get this—uh—fever out of—out of my head.

T53: Is the point, David—it's like you feel pissed off at the voices because you feel like you haven't had an easy time of it. Nobody's coddled you. In fact, your parents have had you hospitalized and taken away in cars and things like that, and so it's been very hard on you, and then to have the voices mock you is very upsetting, or just angers you?

C54: Right, yeah, one time I was at a flea market with my sisters and my mom, and the voice on the radio says 'that's why we're mocking you!' and what she's referring to is, is this, kind of, rattling I do with my fingers, uh, I mean, I—I uh—I didn't decide to break my fingers. They just got broken in accidents.

T54: But you're being held responsible for your fingers rattling, when it's not your fault, that is, it was accidental that your fingers have been broken in accidents.

C55: Right. I guess. I mean I have read *To Kill a Mockingbird*. Sometimes I feel that that uhm, that this Boo Radley [a reference to a character in *To Kill A Mockingbird*] that stays in the house all the time, and has some strange affection for little kids, you know, it's kind of one part—part of things that I deal with, so, anyway. I uhm—I uhm—met—met—mad. . . . I guess uhm that I—I uhm—ma—make uh—fe—focus on certain thoughts, you know, I think that that's what I'm supposed to do and I don't know if I'm suppo—supposed to look at the negative side of things.

T55: And you're confused about the fact that your attention tends to focus on certain thoughts that are negative, but you're not sure if you should be paying attention to those things?

C56: I—uhm—I'm just—really upset because the voices insist on certain thoughts, and I uhm, especially in the last week or so I've been, I've been accepting these things, and real—really becoming very stupid. So, anyway. It is . . .

T56: Is it that you feel kind of demoralized right now, kind of defeated because you've been accepting some things that make you feel stupid?

C57: Yeah. And of course smoking.

T57: Smoking, you've been smoking and that bothers you too?

C58: Yeah. So uh I guess that—that the sa—sem—sss—sensation of—of you know puh—pulling the—somehow I'm really focusing on—on this thing of "trees and

tracks and trying and trips and treking and tra—tra—trap—trafficking" and I can't get these things out of my mind. These t- t- tru—truism and stuff.

T58: You mean it's just like a bunch of words all beginning with "tr," and you just can't get your mind off that groove, kind of, is that it?

C59: Yeah.

T59: And it's annoying to you?

C60: Well, I—I sought—sought. . . . I heard the voices say one—one time something about CIDOC [Centro Intercultural de Documentacion] in Mexico, and they seemed to be saying that they didn't treat me right at CIDOC and eh—a foc—focus on—on that situation is—is not really relevant. I mean I was 18. I did the whole thing by myself. I caught the bus. I didn't get lost. I didn't lose anything—except my passport—which it turns out that I didn't lose anyway, and I went to the embassy to try to get a new one, and I climbed the mountain, Mount Popo, [Popocatepetl] and—and I went on lots of long walks and there's no question that in Chicago I've walked as much as the next guy. And, it is you know at—you said something about mocking. Well I've made that relation before in my mind, you know, with the word *mark*, and with *To Kill a Mockingbird*—*Mockingbird*, you know, and now the voices are saying just a minute ago, "That's Jimmy boy!" and "Tom's great compromise is down the drain!" you know, and that you know I—I have made that association before, I have really—really—don't need to be in intracted—tracted by that.

T60: I'm not sure what happened. Did—you don't feel that I was trying to stimulate some sort of association, did you, by my . . . ?

I think, in retrospect, I was anxious in this segment when he stated that "you said something about mocking." When he ended with his statement that he "really—really—don't need to be intracted," I took his meaning too personally.

C61: No, you were just saying—

T61: I was basically just trying to understand how the voices were treating you, what the relation was.

Here, I should have let David complete his statement because it seems as though he probably did understand my motives and did not make an assumption that I was up to anything.

C62: Right. So anyway, I mean, I think that was just a normal part of the conversation, because I said first, something about going to a flea market and the lady says "That's why we're mocking you."

T62: Well, I'm not exactly sure what the sequence was, but I certainly didn't intend anything by using that term. But what you're telling me is the voices are somehow—or you make these associations between the term *mocking* and *mark* and *To Kill a Mockingbird*, right? And it's kind of disturbing, that bunch of associations.

C63: Right, uhm, that's the kind of stuff that the voices prey on. And I—I know that.

T63: That's the kind of grist for their mill, almost.

C64: Yeah, I know that. You know yesterday I was just thinking about moccasins, you know, eh I—I really don't—don't see it as mocking, I see it as "my cousin," "moccasin." That's all there is to it. But the voices—voices don't make the association either, so why should I? Heh. That—that is just as significant as pair of socks, right? Heh. And uhm—I uhm am—in—am—kind of uhm in—in fo—focusing—and I don't know if that means that I should make associations 'cause that means that I'm trying to focus, you see, and I think that, you know, to build some kind of personal inference around it, is not what I'm trying to do. And I I think that it—it's—it—intractable anyway.

T64: David, I'm not sure I followed much of what you just said, but it—I guess part of what I understood was you're confused in a way of what to pay attention to in your mind? It's like you want to focus, but you don't—

C65: It's just "Monkey see! Monkey do!" The voices—the voices continue making assertions, and I—I—I just want to say something back, but I guess I'm too eh—exc—exssss—eh—eh I think it's—it's excluding, you know, I can't—I can't forget, you know, that, you know, I have done some things which were, you know, mistakes, that they weren't, you know, what was lucky, you know.

T65: You feel I guess some remorse, you rememb . . . [tape flip] you can't quite forget about those, or you can't put them out of your mind, even though they're in the past.

A more accurate response might have been "You'd really like to argue back against the voices but then you think about some mistakes you've made and it kind of undermines you from opposing them."

C66: Just uhm, all I know is last year when I was completely out of control, I wrote something about "Jimmy boy" and "times of great compromises of certain compromises or uncertain times." And that was meaningful to me because I have this tendency to want to share . . .

T66: Share with other people.

C67: Right. And it's—sh—it's—it's nothing wrong with that, and that's what the voices are preventing. And that's about all I have to say.

T67: It's like the voices are preventing you from sharing your life or your thoughts with other people and that makes you mad.

C68: Right, right. They're preventing me from using my basic wits now. I don't expect to be any anybody special. I just expect to feel camaraderie with other people, that's all.

T68: It's not like you want to be a star or a special person, but you'd like . . .

C69: I have no respect for stars. I think they're all idiots.

T69: But you would like to feel a sense of camaraderie with other people.

C70: Right, there's no question that America's a bunch of—a bunch of real asinine bastards trying to get their trip together. And I could care less. The voices have totally ruined my trip.

T70: And you're pissed off at them because they've ruined your life.

I should have used his term *trip* instead of the word *life*. I am not sure that *trip* is as far-reaching as the word *life*.

C71: Well, huh, nobody's ever going to get their trip together, so that's just too fucking bad. Michael—Michael Jackson is supposed to be everybody's hero and the guy's even vainer than I am.

T71: When I mentioned the term *stars*, it seems to me you then started—it reminded you of your antipathy toward a lot of these rock stars—is that what happened?

C72: Yeah.

T72: Uh huh.

C73: I mean, you know, when you're 15 years old, you know, and somebody's saying something about like "leper messiah, he sucked up into his brain," you know—you know, same to you! I mean it—it's not—it's—not music, okay?

T73: David, I am going to need to stop in a minute.

C74: Okay.

Assessment of the Session

A close look at this session shows a large number of tracking or empathic following responses along with "true" empathic responses. An empathic "following" response is a tracking response in which the therapist is simply verbally noting what he or she

is being told. An example of a simple tracking response is seen in T37. Wilczynski, Brodley, and Brody's "Rating System for Nondirective Client-Centered Interviews—Revised" (2008) defines a *true* empathic response as one in which the therapist *experiences* an inner understanding of the client's communication. An example of a true empathic response is T70 where I say, "And you're pissed off at them because they've ruined your life."

There are mistakes in the session in which I interrupt or distract David, although I do not feel—as I read the transcript—that those mistakes led to any significant effect in this session. I believe that my behavior in the session was largely consistent with the stance of principled nondirectiveness. For instance, when I make clear to David that I am not following him completely or when I explicitly check by asking him "Is that your point?" the implicit message is that I value being corrected; that his account of reality is of the utmost importance. Hopefully, the client who experiences consistent, effortful, empathic responding concludes correctly that your intention is simply to understand, that you value getting his expressed meaning accurately and that you actively *want* to understand. Serendipitously, the empathic understanding response form that is given by the therapist to check her own understanding also conveys the therapist's unconditional positive regard.

There was a series of client statements and my responses at beginning at C29 through T41 where the momentum of the session subtly quickened and where I felt we were very much in contact with each other. I felt my responses were on target and that David experienced my accurate empathic responses with enthusiasm and relief and greater connection. Clearly, this client is fully capable of representing his experience in the session, of using the "affordances" offered in the therapy situation (Bohart, 2004). I think it is possible that David experienced at *least some temporary comfort in being believed, understood, and accepted. Brodley who worked for* five years in an institution with persons with diagnoses of schizophrenia remarked that these clients tended to "clear up" in the process of being carefully understood at least for the duration of the session. This point is important as it points to the possibilities for greater comprehensibility and support if it were possible to provide a consistent climate of the therapeutic conditions. Currently, there is an international group called *Intervoice* as well as English, German, and Danish groups for "voice hearers" that function as a source of support for persons who have to cope with voices (Romme, Escher, Dillon, Corstens, & Morris, 2009, p. 77). The point here is that there is an array of interpersonal options for assistance and care.

Rogers's motivational theory consists of the axiom of the actualizing tendency, which is the directional life force characteristic of all life forms. A client-centered therapist (as Rogers outlined in his "Attitude and Orientation of the Counselor" in 1951) tentatively, and later with more experience, more confidently, holds the hypothesis that the client before him has the capacity for development, self-regulation, and growth—the capacity to make choices. Even when those choices may turn out to be deleterious or harmful to the person, this process of self-determination progresses toward greater self-differentiation, awareness, and behavioral regulation and, through learning from one's mistakes, better decisions.

When an unafflicted client is working with us, the therapist enjoys great satisfaction in observing the pace of personal change, the increasing self-authority, greater capacity for independent action, and stronger internal sense of self as the locus of evaluation. When we answer the call of the other, the one who is greatly afflicted, one whose basic expression is enigmatic or disorganized or dysfluent, the tendency to abandon the belief in the growth hypothesis arises out of fear of our own inadequacy and fear for the client.

This fear is not irrational. Functioning as a client-centered therapist in today's clinical culture is a great challenge. Graduate students are encouraged to undertake a suicide assessment the moment the client expresses a wish for death as a relief from suffering. In these crisis situations, a therapist needs to possess a high degree of self-confidence and a confidence in the client and be willing to risk his or her professional safety to stay

with a client who is experiencing frightening chaotic inner events—voices that are experienced as intrusive or insulting, threatening to the client, or demanding that the client act against others close to them. Rogers has stated that at these times of crisis, what is needed is not to abandon the hypothesis. Instead, it is the time in which faith in the client's inner resources for change and self-direction is most needed.

A PHENOMENOLOGICAL UNDERSTANDING OF LIVING A LOST LIFE

Client-centered therapists seek to understand the client's immediate, moment-to-moment communication. Over time, these moments of understanding allow us to build a more elaborated and complex understanding of the client's frame of reference. This two-way process of communication and reception is a dynamic one that implies we are always tentative and willing to revise our grasp of meanings. I believe we can assume that the person seeks to be understood, even when the client is noncommunicative. Involuntary clients—such as those persons who are incarcerated or institutionalized or children and adolescents who are remanded to therapy by authorities—may be exceptions.

As the therapy relationship persists over time, I experience the growth of my own understanding generated by the process of empathic responding through having the understandings endorsed by the client, or, conversely, by being corrected. The client's take on things and use of particular words and phrases takes shape in my mind as I construe her communications in terms of my own personal framework of meanings, memories, emotional history, and the conscious and unconscious assumptions I bring to the interaction from my own "location" in the social world. From my own social and cultural location, I strive in this instance to encounter David, a man who has lost his life as he knew it.

In this session and throughout our therapy relationship, David recalls and reiterates the devastation which he has experienced; the intrusion of voices, the loss of his self-determination through forced hospitalizations, and forced injections of neuroleptic medications. His affliction and the inadequate approaches to meeting his needs have led to his loss of not only the potentials for growth and development but also the fundamental experience of a comprehensible self. As he has aged, David is left behind unable to operate on his world and so instead succumbs to a passivity so common in our mental-health system where the medications are heavily sedating and there are no opportunities for meaningful contribution to the public world.

When reading Jonathan Lear's book *Radical Hope* (2006), I was struck by the similarity between the catastrophic loss experienced by the Crow nation and the analogous loss of one's personal world. In the book, *Plenty Coups*, the last great Crow chief, gives this account:

> I have not told you half of what happened when I was young. . . . I can think back and tell you much more of war and horse stealing. But when the buffalo went away, the hearts of my people dropped to the ground, and they could not lift them up again. After this nothing happened. There was little singing anywhere (Lear, 2006, p. 2).

Lear proceeds to conduct an ethical inquiry into the impact of a radical loss of the whole framework of meaning within which the Crow people understood their lives. "After this nothing happened" meant that all of the large and small acts of living—making ready for battle, decorating one's horses for battle, planting one's coup stick, displaying scalps won in battle—were no longer possible except as *enactments* of past exploits. Being a Crow warrior whose life was given meaning through constant warfare and the building up of courageous character in war became impossible once the buffalo were gone and the Crow were forced to adopt a settled agricultural life.

This book illuminated for me, although the situations are radically different, the profundity of "normal" loss as opposed to the loss of the whole framework of meaning. After the voices came, it is not too much of an exaggeration to say that David lost his life as he knew it. The avenues to a larger world of relationships and experiences—his social visibility as a person who counted to others—vanished as he could no longer inhabit those contexts. As Lear explains, losing one's structure of meaning—one's traditions, one's culture—also entails losing moral definitions and evidence that one is living a courageous life.

> One would experience a rip in the fabric of one's self. If we think of the self as partially constituted by its most basic commitments, then in jettisoning those commitments one would be disrupting one's most basic sense of being (Lear, 2006, p. 65).

Just as David lost his visibility and position in society, his circle of friends, the chance for affection and sexual love, children and family, the chances for interesting work and new learning, his family lost the beautiful, creative, brilliant child they had loved and nurtured. And we, as a society, lost all the possibilities for creative, productive engagement David might have offered to us.

For the individual labeled and diagnosed as suffering from severe "mental illness," no matter the source or etiology of the affliction, imagine the suffering of experiencing the ongoing torment of insulting voices that threaten you or talk nonsense and find that no one believes you. Attempts to convince David that what he was so vividly experiencing was not "real" but was "schizophrenia" were undoubtedly well intentioned but only left him even further estranged. This experience-distant response offers no real explanation and no help. This radical disjuncture between David's perceived reality and "consensual reality" constitutes invalidation of his personhood. It is a way of being cancelled. You are no longer respected as a person who has the right and the capacity to tell truth. You don't count—only the "illness" counts—and that transit to the land of the sick justifies almost total control of your decisions.

Stolorow captures the alienation and estrangement that accompanies emotional trauma and attributes a person's reaction to the trauma in terms of his loss of everyday certainties that he terms *absolutisms*.

> When a person says to a friend, "I'll see you later" . . . these are statements . . . whose validity is not open for discussion. Such absolutisms are the basis for a kind of naïve realism and optimism that allow one to function in the world, experienced as stable and predictable. It is in the essence of emotional trauma that it shatters these absolutisms, a catastrophic loss of innocence that permanently alters one's sense of being-in-the-world. Massive deconstruction of the absolutisms of everyday life exposes the inescapable contingency of existence in a universe that is random and unpredictable and in which no safety or continuity of being can be assured. Trauma thereby exposes "the unbearable embeddedness of being" (Stolorow & Atwood, 1992, p. 22). *As a result, the traumatized person cannot help but perceive aspects of existence that lie well outside the absolutized horizons of normal everydayness. It is in this sense that the worlds of traumatized persons are fundamentally incommensurable with those of others, the deep chasm in which an anguished sense of estrangement and solitude takes form* (Stolorow, 2011, p. 145, my emphasis).

We could say that not only is David's world "fundamentally incommensurable with those of others" but also it is very likely that few others realize that anything so devastating has occurred. Most of us have no reference for this experience of finding the world you have known slowly vanishing—and being replaced with an incomprehensible moonscape inhabited by hostile whisperers who never stop.

The institutions of our culture have failed persons who undergo these experiences, making social control the goal instead of supporting the development of self-regulation and self-determination. David has stated that the medications have never stopped his voices and that they make him "stupid." His mother observes that at this point in his life, at age 53, his previous brilliance, creative intelligence, and psychomotor mastery as a superior swimmer and athlete have greatly diminished, certainly in part because of decades of neuroleptics. A new vision of care is needed; in this, European countries such as the United Kingdom, Denmark, the Netherlands, and France are more advanced than the United States (see Romme et al., 2009).

An environment that might be closely organized around and attuned to each person who is currently "severely mentally ill" is both imaginable and fundable if our society changes its priorities. Clients would have access to personal assistants and caregivers whose mission would be devotion to the emotional and physical health and security of the person and to take seriously and at face value his communications regarding his day-to-day fluctuations in mood and energy. Group sessions might be arranged to help the person respond to hostile or threatening voices; ceremonies of protection could be performed. His or her belongings and possessions would be guarded against theft or carelessness. The person would be given opportunities to earn money in many different ways and to avoid work when overwhelmed without censure or disappointment from the community. Spiritual practices, artistic opportunities, and ways in which the person might help others and give care to others would dignify the person's life.[2]

Principles of respect, acceptance, and appreciation of the afflicted person would govern these communities, all of which is obvious but extremely hard to realize in a culture that wants to distance itself from the "alien" and in which the "gold standard" life is defined by earning power and conspicuous consumption. However, it is clear that more collectively oriented cultures in which people live together in larger compounds and have opportunities for participation result in longer lives and better recovery (van Blarikom, 2006, pp. 161–162). A deep moral and political shift will need to occur in our culture to realize this humane model of care. Most important would be the freedom of the person to experiment with possible modes of healing. There would be no more coercive practices, unwanted injections, forced hospitalization except under extreme circumstances (such as committing violent crimes). Many who work in institutions may bridle at this idea, asserting that that is what already happens and that these unfortunate practices are necessary to protect the person and others. Perhaps in some cases this may be true. In many, it is not (Szasz, 1997).

A PRACTICE OF HOPE

I hope a reading of the transcript offered here robustly displays the selfhood of this client. David articulates what he perceives to have occurred in his life—the destructiveness and devastation he has endured. In most of our sessions, his interactions with me satisfy the first of Rogers's necessary and sufficient conditions, which is two persons are in contact (Rogers, 1957). Contrary to many descriptions of persons who are diagnosed with schizophrenia, David resembled the majority of the clients I have worked with over the last 38 years: he participated in therapy voluntarily; he desired to communicate and be understood; his frame of reference was, to a large extent, accessible. In spite of some

[2]Although there have been attempts at creating such communities, they are works in progress, and it is interesting that the more successful programs have found that the model of *individual placement and support* (IPS, or treatment tailored to the client's own preferences and interests) has better outcomes than other models such as *psychosocial rehabilitation* (PSR) (Mueser et al., 2004, p. 485).

expressions and language that I was not able to understand, I did not need to apply "process diagnoses" (Warner, 1998, 2006); nor did I see David as *pre-expressive*, which Prouty describes as a person who is not yet in contact and does not indicate any desire to communicate (Prouty, 1994). I am in agreement with Warner's statement regarding the ongoing debate over etiology of severe mental illness.

> As with client-centered work in general, this model of client-centered work with "thought-disordered" psychotic experience doesn't depend on resolving issues of etiology. Whether the cause of psychotic experience is primarily biological, . . . primarily developmental/familial . . . or some mixture of the two, the human impulse to communicate and to process experience remains. A client's having a safe space in which to sort through thoughts, feelings and choices maximizes the person's potential for having a positive sense of self and confidence in relating to others in the world (Warner, 2002, p. 470).

Although "schizophrenia" has been reported by many researchers, anthropologists, and native healers, persons who have been so categorized do not constitute a clearly delineated group. As is apparent from stories such as Georgina Wakefield's account of her son's affliction, *Living with Christian* (2010), and the accounts of other people who hear voices, in many cases persons adapt, sometimes with support of medication, to these voices and to living with immense difficulties of this affliction. David has not had the advantages that persons living in Europe have had where groups organized for "voice hearers" are given vital support (Romme et al., 2009). By contrast, David's story is a long, solitary struggle to cope with the physical and social sequelae of living with this condition.

Carl Rogers grew up with experiences in agriculture. From an early age, he was sensitized to the processes of life and never ceased to be inspired by the natural world. In his book *A Way of Being*, Rogers illustrates the growth tendency in recalling his root cellar from childhood:

> 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 two or three 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. In dealing with clients whose lives have been terribly warped, in working with men and women on the back wards of state hospitals, I often think of those potato sprouts. So unfavorable have been the conditions in which these people have developed that their lives often seem abnormal, twisted, scarcely human. Yet, the directional tendency in them can be trusted. The clue to understanding their behavior is that they are striving to move toward growth, toward becoming. To healthy persons, the results may seem bizarre and futile, but they are life's desperate attempts to become itself. This potent constructive tendency is an underlying basis of the person-centered approach (Rogers, 1980, pp. 118–119).

A poem David wrote strikes a similar chord of life still striving and ultimately not lost. He said at one point, many years into his affliction, "I still have hope that my life will be interesting."

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