The University of Nottingham

# Identifying Helpful Aspects of Therapists' Empathic Responses that Facilitate Clients' Involvement in Experiencing

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## Abstract

**Background:** The aim of this study is to first, investigate the influence of therapists' empathic responses on clients' involvement with their experiencing and secondly, to identify what are the helpful aspects of therapists' empathic responses that can facilitate this involvement.

**Methods:** 12 cases were selected from a research clinic that offers person-centred experiential therapy. For each case, four segments were chosen from the 1st, 4th, 9th, 14th sessions for transcribing and analysis. All the segments were then rated through running ratings using the client and therapist Experiencing Scales (EXP), and the ratings were coded into whether they are internally or externally focused experientially. Statistical analysis was performed to determine the relationship between therapists' focus and the clients' EXP. A qualitative process analysis was then used to identify what are the helpful aspects of therapists' responses that facilitate clients' involvement in experiencing by means of comparing facilitative and less facilitative responses differentiated by how they influence clients to focus internally or externally.

**Findings:** Statistical analysis has suggested that the experiential focus of the therapists' responses, whether internal or external, would influence clients to focus in a similar manner. Four helpful aspects of therapists' responses were identified: (a) referring to the implicit felt sense of the client, (b) allowing space for clients to derive their own meanings from experiencing, (c) acknowledgement of immediate inner processes and (d) focus on the clients' self-agency.

**Conclusions:** This study is an abbreviated version of the new method called the comprehensive process analysis as devised by Murphy, Eilliot and Carrick (2019). The study has further affirmed the value of phenomenological research grounded in actual therapy processes and future research is recommended to make further contributions to person-centred theory.

# 1. Introduction

The concept of 'experiencing' is first construed by Gendlin (1961). It refers to the ongoing implicit felt sense within the human organism, which human beings can repeatedly refer to in order to derive new meanings with their experiences. This concept then becomes an important concept with person-centred therapy, especially in the formulation of empathic understanding. Rogers (1966) explicated that the communication of empathic understanding plays a central role in effecting therapeutic change and sees empathic understanding as an ongoing process of being focused on the immediate phenomenal world of the client without ever stepping out of it. He explained that client-centred therapists not only respond to the obvious verbalizations made by the clients but also aims to dip into the implicit meanings that is in the client's experiencing. He then concurred with Gendlin (1961) that the

> "… optimal client-centred response attempts to refer to, and to formulate, the client's present felt experiencing. It thereby helps the client to formulate it, and refer directly to it, so that the better and more differentiated conceptualizations can be worked for, so that he can feel his present feelings more deeply and intensely." (Gendlin, 1961, p. 240)

In 1980, Rogers further explicated that the purpose of empathic understanding is to help the client focus on what they are experiencing in the immediate moment and through this, help them to "experience meanings more fully and move forward in their experiencing" (Rogers, 1980a, p.142). Rogers (1980b) also further describe how empathic responses could have different degrees of effectiveness based on what the empathic response was targeting at. When the therapist only communicates a superficial understanding of the client's experience, it inhibits further self-exploration. If the empathic response allowed clients to experience that they were being understood from their frame-of-reference, it would be an effective empathic response. However, Rogers believed that the most facilitative kind of empathic response would be one that dips on the subtle meanings at the client's edge of awareness, which might be something that the clients felt in their experiencing but have yet to symbolise to awareness.

From these theoretical underpinnings, we can see that clients are influenced in therapy by how it facilitates them to get in touch with their inner experiencing. When therapists come from an evaluative and external understanding of clients, clients could become removed from their ongoing contact with experiencing. Meanwhile, if therapists are focused on the clients' immediate phenomenological world and convey empathic responses that dip into the implicit meanings and feelings within their experiencing, it could help clients to focus in on their own experiencing and discover previously felt but unknown elements in themselves.

In this paper, we would attempt to study this phenomenon of how therapists focus on clients' experiencing and how this facilitates the clients' involvement with their own experiencing. First, we go through a brief literature review on the existing relevant measures and previous research done on this topic. Secondly, we will explicate the methodology for the study, followed by the results for both quantitative and qualitative analysis. Lastly, the implications and limitations of the research will be discussed.

## 2. Literature Review

To study the quality of clients' involvement with their experiencing, the Experiencing (EXP) Scale (Klein, Mathieu, Gendlin & Kiesler, 1969) was created to measure client's experiencing as a process variable in therapy. The scale is an observer-rated scale that rates client's verbalisations in therapy on a seven-point continuum.

At the lowest stage of this scale, clients are remote from their own experiencing, and their verbalizations are only about external events without any personal involvement in it. Stage 2 of the scale indicates a level of personal involvement in events without any verbalisations of feelings. Stage 3 indicates verbalisations that contain expression of feelings, but these feelings are rooted in the external circumstances and expressed in a limited fashion. Stage 4 of the scale signifies an important transition where there is a shift in the quality of involvement with experiencing. At this stage, the clients move from a focus on external events and abstractions to a focus on their subjective flow of experiencing within them, using it as an inner referent to derive meanings and as a basis of their communications. At Stage 5, clients continue to focus on their inner referent to explore and elaborate a problem or struggle

related to their inner process. Stage 6 indicates that clients are able to symbolise some resolutions for the identified problem in Stage 5 through their experiencing. Finally, in Stage 7, it represents that the experiential resolution is expanded and applied to other aspects of their experiences. (see Appendix 1)

Rogers, Gendlin and their team at the University of Wisconsin have used this scale in many of the earlier studies (Klein *et al,* 1969). One of the important findings was that clients who were considered successful had a higher experiencing level at the start, middle and end of the therapy compared to those who are considered less successful. This indicated that clients who were less involved with their experiencing from the start, would likely to benefit less from therapy than clients who were already quite in touch with their own experiencing. It was found that the average EXP scores across therapy were associated with other outcomes measures of therapy, confirming the validity of the EXP scale. However, no consistent patterns or trends of EXP were found to be related to successful therapy except that successful cases maintained EXP more consistently and had less backsliding. This implies that even for successful cases, there was no linear increase of EXP over time.

During the Wisconsin Project (Rogers, Gendlin, Kiesler & Traux, 1967), researchers found that there was a positive correlation between EXP and Accurate Empathy, as well as between EXP and therapists' congruence as perceived by the client. However, these findings were not widely replicated in later studies. In an analysis of 176 segments from 13 patients, Jennen, Lietaer and Rombauts (1978, cited in Klein et al., 1989) found that there was no overall correlation between EXP and Accurate Empathy. However, they found that EXP was significantly higher during segments where Accurate Empathy was also rated as high, suggesting that EXP scores could vary with therapists' behaviour at different sessions.

Overall, there was no evidence that suggests that EXP scores were consistent with constructive therapeutic change (Klein, Mathieu-Coughlan & Kiesler, 1986). Instead, higher EXP scores indicate a mode of productive functioning where the clients were using their experiencing in therapy and this mode varies from moment-to-moment, constantly influenced by different contexts such as the content of the clients' verbalisations and the experiential focus of the therapist. It was learnt that when experiencing was more frequently utilised by clients as a direct referent in therapy, it would likely lead to better therapeutic outcomes. Yet, this does not imply that EXP scoring would improve over time. Thus, the frequency of being involved with experiencing (i.e. EXP scores 4 to 7) are likely a better predictor of

outcomes rather than comparing sessional EXP scores. This implies that research that aims to measure how therapists' offered condition affect EXP scores over time or to find out how changes in EXP scores predict therapeutic outcomes are not likely to yield meaningful results.

To measure the extent of therapists' focus on clients' experiencing, Klein *et al* (1986) created the Therapist Experiencing Scales. However, it was not validated and there was no training manual to train raters to build up reliability. However, it offers a way to rate therapists' behaviour in relation to experiencing. There are two parts of the scale – Therapist's Referent (TR) and Therapist's Manner (TM). TR measures the extent or aspect of clients' experiencing that therapists' words are "pointed" to. Every stage of the scale is a parallel to the clients' Experiencing Scale and the only difference is that TR scale represents what therapists' words point to while Experiencing Scale measures the clients' own involvement with their experiencing (See Appendix 2). On the other hand, the TM Scale is a measure of therapists' own involvement with the clients' experiencing process. The lower end of the scale represents therapists' detachment from clients' experiencing while the higher end of the scale represents therapists being so involved with clients' experience that they are co-experiencing together.

With the introduction of Therapist Experiencing Scale, it opened up more potential for studies on how therapists' responses might affect clients' involvement with experiencing. As Klein *et al* (1986) have observed, the association between therapists' intervention and client's EXP scores were stronger and more consistent in finer-grained sequential analyses and single-case studies compared to studies that tried to measure global and pervasive ratings such as measuring overall EXP scores in relation to clients' perception of therapeutic conditions. Thus, rather than measuring overall EXP scores in relation with therapeutic conditions and therapeutic outcomes, the direction of this current study is to zoom in on the moment-to-moment experiencing scores for both the clients and therapists to observe how they interact with each other.

Two of such studies have been found and they were both unpublished doctoral dissertations. The first one was done by Hitz (1994) where he analysed 19 different sessions from different clients from tape recordings. 12 of these sessions were cognitive-behavioural therapies while others come from psychodynamic or eclectic approaches. None of the sessions was person-centred therapy. The unit of analysis was the exchange of speech turns consisting of the client's initial statement, the therapists' responses and the client's subsequent statement. All the clients' and therapists' statements were rated using the Experiencing Scales. In general, it was found that clients' EXP score would either

stay the same or increase following a TR or TM score that was higher than the initial EXP score. Meanwhile, when therapists' scores were lower than the clients' initial statement, the subsequent clients' statement would likely to be lowered with statistical significance. While this study has shown that it was helpful for therapists' responses to be on a higher experiencing level than the clients' statements, there needs to be caution on how this finding is interpreted. If a therapist holds the intention to "deepen" the client's experiencing and attempts to bring clients' to a higher stage of experiencing, the therapist would have assumed an expert role by not trusting the clients' own process and their own pace with their processes. By doing so would mean a lack of trust in the clients' actualizing tendency and to step out of the person-centred approach. As such, this methodology of measuring whether therapists are "deepening" the clients' experiencing process is not likely suitable for the person-centred paradigm.

In another study, Adams (2010) conducted a study with 34 participants who underwent either client-centred therapy or process-experiential therapy. She analysed a total of 1082 client-therapist-client exchanges and converted the EXP scales into a dichotomous manner where scores of 1-3 were considered as external experiential orientation and scores 4-7 were considered as internal experiential orientation. She found that clients were approximately 9 times more likely to shift from an external experiential focus to an internal experiential focus if the therapist was focused on their internal experiential world. Another finding was that the mode of the therapists' experiencing scale and the proportion of the therapists' internally focused responses were correlated to outcome measures of self-esteem and symptom reduction. She postulated that the best therapists-client interaction is one which the therapists focus consistently on the client's inner experiencing and the client being open to access their own experiencing.

Adams' (2010) methodology of splitting the EXP scales in a dichotomous manner to internal and external focus resolved the problem in Hitz's (1994) study. The focus of person-centred therapists is not about trying to bring clients' experiencing to a deeper or higher level but to stay empathically with the client's moment-to-moment experiential world. Even when the clients' verbalisations are externally focused (i.e. between stage 1-3), therapists' responses can still refer to what the clients are experiencing internally. The role of person-centred therapists is to empathically sense the immediate internal experiencing of the client and checking with the clients if their understanding is correct while trusting the clients to be their own best guide for their own processes. Hence for this research, we would be adopting Adams' (2010) method of splitting the scale into a dichotomous manner of internal and

external experiential focus; we were less interested in whether therapists were bringing the clients to a deeper level of experiencing and more interested in whether therapists were able to empathise with the inner experiences of the client and what are the immediate effects of these empathic responses.

Although Adams' (2010) has provided extensive quantitative data on how therapists' responses affect the immediate experiencing of the clients, there was still a lack of literature that explicate what kind of therapists' responses would be helpful to facilitate clients' immediate involvement with their own experiencing. Brodley (1996) argued that in person-centred therapy, it is the therapist's true empathic understanding of the client that stimulates clients to be in touch with their internal experiencing. Although the researcher concurs with this statement, more can be done to differentiate and explicate what this 'true empathic understanding' may look like in the therapy process. This study was an initial attempt at a bottom-up inductive process to understand how therapists' empathic responses facilitate clients' involvement with experiencing using transcripts of actual therapy sessions. We would use a two-pronged mixed method. The first part of the research would be a quantitative data analysis using the experiencing scales. The purpose was to find out how the experiential focus of the therapists' responses influences clients' involvement with their own experiencing. The second part would then be a qualitative analysis of the therapists' responses, guided by the quantitative data. The endpoint of this study was to find out what are the helpful aspects of therapists' responses that facilitate clients to be involved with their experiencing.

# 3. Methodology

## 3.1 General context of research

The data for this research was collected from existing recordings of therapy sessions that were provided at the Human Flourishing Project (HFP). The HFP is a psychotherapy research centre that is linked to the University of Nottingham. This ethics for this clinic has been approved by the University of Nottingham, School of Education Research Ethics Committee and specific ethics approval for this research has been sought. All the recordings that were obtained for this research were therapy sessions done by therapist trainees who were doing placements. The form of therapy offered is Person-Centred Experiential Therapy (PCET). All of the clients were above 18-year-old and were self-referred, they

have all signed informed consent for their recordings and self-rated questionnaires to be used for research purposes. To protect the confidentiality and anonymity of the clients, all the names, gender, dates and any other sensitive information in the transcripts presented here were altered.

## 3.2 Sample Selection

Clients who have completed 15 or more sessions in the clinic were chosen as the sample for this project. At the start of this project, the total sample size with the available data was 65 clients. Forty of the clients were randomly selected for sampling. However, due to the poor quality of the audio recordings during the chosen sessions, 15 cases within this group were replaced with the next randomly selected clients from the sample pool. For each client, four segments were chosen from the 1st, 4th, 9th and 14th sessions to be transcribed. While this research project initially aims to transcribe all of the selected segments for the 40 clients, only 25 transcripts were completed due to resource limitations and time constraints. 12 sets of the transcripts were randomly selected from these completed transcripts to be used in this study.

## 3.3 Segment sampling and length

The 1st, 4th, 9th and 14th sessions were chosen for sampling due to various reasons. The 1st session was chosen to capture the initial baseline experiencing scores. The 4th, 9th, 14th sessions were chosen because they were full-length 50-minute sessions where clients did not need to fill up any questionnaires which might affect the length of sessions. They were also the sessions right before the 5th,10th and 15th session when clients filled up the research questionnaires at the beginning of those sessions so corresponding data from the research questionnaires could be used for future research.

Klein *et al* (1969) recommended that the segment length to be about 5 to 8 minutes as they found that the reliabilities, range and discriminatory power of the experiencing scales were independent of the segment length kept within this range. The study has chosen 8 minutes as the segment length for rating and analysis so as to expand the possibilities of capturing EXP changes within the segment.

In earlier studies, Klein et.al (1969) found that group differences emerged most noticeably towards the end of the session. Therefore, we selected the 70th percentile of each session as the time point to obtain the segment. This was usually at the 35th minute of a 50-minute session, but it might be earlier if the sessions were shorter due to various reasons. These segments were then fully transcribed

for rating and analysis. Each client would thus have 4 corresponding transcripts that were each 8 minutes in length. In total, the study involved analysing 384 minutes' worth of transcripts from 12 clients at 4 different time points.

## 3.4 Rating

The Client's Experiencing Scale and the Therapist Referent portion of the Therapist Experiencing Scale were used to rate the transcripts. There was a purposeful omission of using the Therapist Manner portion of the Therapist Experiencing Scale as the stages of this scale was not sufficiently differentiated, especially at the higher stages of the scale and there was no training manual to ensure that the scale could be used reliably.

As the main transcripts would be rated by only the researcher, who is a post-graduate student in an MA course in Person-Centred Experiential Therapy, an expert rater was invited to establish interrater reliability with the researcher so as to ensure that the researcher has reached an acceptable level of proficiency in rating. Sixteen 8-minute segments were randomly selected from the initial sample of 40 clients to measure interrater reliability. An Associate Professor in Clinical Psychology with a specialization in Focusing-Orientated Therapy was invited to do the ratings with the researcher. Both of the raters have revised the Training Manual provided by Klein *et al* (1969) before commencement of the rating. The segments were transcribed by the researcher and printed out for both of the raters to rate. Each transcript would go through the process of running rating, where each speech turn of the client and the therapist would be given an individual rating. When a speech turn is long, the peak score of that particular speech turn is taken as the score.

There was a total of 170 clients' speech turns (client's EXP scale) and 169 therapists' speech turns (TR scale) that were rated for interrater reliability. The interclass correlation formula (Ebel, 1951) was used with the two-way mixed model and the absolute agreement type. The intraclass correlation coefficient for the EXP and TR rating is .78 and .86 respectively, indicating there was good reliability between the raters. The subsequent rating of the transcripts by the researcher could hence be considered reasonably reliable.

## 3.5 Quantitative Data Analysis

48 segments from the 12 different clients were subsequently rated by the researcher with running ratings of the client's EXP scale and the TR scale. Subsequently, the ratings were coded on whether they were internally orientated (I) or externally orientated (E). Scores from 1 to 3 were coded as E, while scores from 4-7 are coded as I. Internal orientation refers to the attention on the subjective felt flow of inner experience as a referent, while an external orientation refers to the lack of such attention. This way of coding was based on the delineation by Klein *et al* (1989) that Stage 4 of the EXP scale indicates a shift in the quality of involvement with the client's experiencing from the external to the internal. After the coding, each exchange that consists of a client's initial statement (C1), the therapist's subsequent statement (T) and the client's subsequent statement (C2) were treated as one unit for analysis with the ratings. The C2 in one unit would be the C1 in the next unit. For consistency within this study, each of such unit was named as a CTC exchange. There were 8 different permutations based on the coding of each individual CTC exchange, namely: III, IEE, IEI, IIE, EEE, EII, EIE, EEI. For example, IEE would imply that a client was initially focused on their experiencing, and the therapist subsequent response was focused externally, and the client's subsequent response also became externally focused.

The rating and coding of this data would then be analysed through using contingency tables and the Mantel-Haenszel test (Mantel & Haenszel, 1959) would be used to calculate the odds ratio. The results would give us an idea of how likely the client's experiential focus would be influenced by the experiential focus of the therapist's response.

## 3.6 Qualitative Data Analysis

The quantitative data did not show what happened in the sessions and therefore was unable to explain the relationship of client's EXP scores and the Therapist Referent score. As such, a qualitative analysis was done for all the 48 segments of transcripts. The method of analysis was an abbreviated form of the comprehensive process analysis as adapted by Murphy, Eilliot and Carrick (2019). The task was to identify themes and patterns from comparing facilitative and less facilitative responses, which was determined by the way they influence clients to focus internally or externally.

Each individual transcript was rated as a whole, with written notes and observations of what was happening in each speech turn. Subsequently, the CTC exchanges with the written notes were then grouped together according to the 8 permutations of I and E to see if there were similar themes in

therapists' responses within the different permutations. More attention was paid to the groups IEE and EII, as it represents a change in the clients' involvement with their own experiencing after the therapist's response. Responses within permutations III and EEE were also analysed, especially when this pattern lasted over a few exchanges within therapy, to explore how therapists' responses may influence clients to have a consistent involvement or non-involvement with their experiencing. Finally, some of the exchanges of IIE and EIE were analysed, to see if there were other contributing factors within the therapists' responses that might not be facilitative. Similar themes were identified, grouped together or further differentiated if the need for differentiation emerged.

In summary, the data would identify two sets of themes, that is the facilitative and less-facilitative therapists' responses in regard to the involvement of clients' experiencing. These two sets of themes were then compared and contrasted with each other to identify what are the helpful aspects of empathic responses that could guide therapists to be more facilitative of client's experiencing.

# 4. Results

## 4.1 Quantitative Findings

A total of 526 CTC exchanges were rated for analysis. This data would be separately analysed as two different sets of data. The first set of data (n=375) consists of client's initial responses (C1) that were externally focused (E). The aggregate data is presented as a contingency table in Table 1 below.

| Client's Initial Response (C1) with external focus (E) | Client's subsequent response (C2) with external focus (E) | Client's subsequent response (C2) with internal focus (I) | Total |
|---|---|---|---|
| Therapist Response (T) with external focus (E) | EEE<br><br>270<br>(72%) | EEI<br><br>34<br>(9.06%) | 304<br>(81.06%) |
| Therapist Response (T) with internal focus (I) | EIE<br><br>34<br>(9.06%) | EII<br><br>37<br>(9.86%) | 71<br>(18.93%) |
| Total | 304 (81.06%) | 71 (18.93%) | 375 (100%) |

Table 1

The chi-square test for independence is performed, with the experiential focus of the therapist (T) as one variable, and the experiential focus of the subsequent client's responses (C2) as the other variable. The general association measure was 62.81 ($p<0.001$), which indicates the experiential focus of T and C2 were not independent variables. The Mantel-Haenzel Common Odds ratio was 8.642 within a confidence interval ranging from 4.8 and 15.53 ($p<0.05$). These statistics tell us that the clients were approximately 9 times more likely to change from an external experiential focus to an internal experiential focus when the therapists' response refers to the internal experiential focus of the client rather than staying with the client's external focus. The statistics show that only about half the clients switched to an internal experiential focus after an internally focused therapist's responses, but this was a substantially higher ratio than if the therapists' responses did not refer to client's internal experiential world. These statistical findings were very similar to what Adams (2010) has found.

Subsequently, the second set of data (n=151) consists of the client's initial statements that were internally focused. The aggregate data is presented in the table below.

| Client's Initial Response (C1) with external focus (I) | Client's subsequent response (C2) with internal focus (I) | Client's subsequent response (C2) with external focus (E) | Total |
|---|---|---|---|
| Therapist Response (T) with internal focus (I) | III<br><br>80 (53%) | IIE<br><br>21 (13.9%) | 101 (66.9%) |
| Therapist Response (T) with external focus (E) | IEI<br><br>5 (3.3%) | IEE<br><br>45 (29.8%) | 50 (33.1%) |
| Total | 85 (56.3%) | 66 (43.7%) | 151 (100%) |

Table 2

Similarly, a chi-square test for independence is performed with the two variables being T and C2. The general association measure was 65.1 ($p<0.001$), which indicated that the experiential focus of the client's subsequent response was dependent on the therapist's response. The Mantel-Haenzel Common Odds ratio was 34.28 with a confidence interval ranging from 12.1 to 97.14. From the data, this suggests that it was 34 times more likely for client to change from an internal experiential focus to an external experiential focus when the therapist's subsequent response was an externally orientated response following a client's statement that had an internal experiential focus.

The results did not indicate nor explain the casual relationship between therapist's response and client's involvement in experiencing, however, it strongly suggests that therapists do influence client's involvement with their experiencing through their responses in both directions. It also suggests that it is much easier for a therapist to bring a client out from an internal experiential focus to an external experiential focus than to bring a client from an external experiential focus to an internal one.

## 4.2 Qualitative Analysis

From the qualitative analysis, four helpful aspects of empathic responses that were facilitative for clients' involvement with experiencing were identified. They are as follows: (a) referring to the client's implicit felt sense, (b) allowing space for clients to explore their own experiencing, (c) acknowledging immediate inner processes and (d) focusing on self-agency.

### 4.2.1 Referring to the client's implicit felt sense

The first helpful aspect of therapists' response is to refer to the client's implicit felt sense through describing and specifying their phenomenology. Therapists' statements that described the clients' phenomenology was one frequent type of empathic responses that were facilitative for clients' involvement with experiencing. These were usually empathic statements that went beyond description of events, behaviours or feelings, and attempted to offer more specificity to illustrate how clients were experiencing their phenomenological world. This is illustrated in Exchange #01302 below.

Exchange #01302

C Part of my naysaying voice has been saying to myself, "you can't actually do it, why in the world do you think you can do it? … And if you can't succeed to the best of your abilities, it's probably no point in doing it anyway."

T For you, it feels like a really heavy weight to be *carrying* around with you. Like, not even like a weight, like something got you on an elastic band.

C It's almost pulling me back.

From the exchange above, we can see that the therapist's statement described how the client was experiencing his feelings and this was aided by the use of action verbs and metaphors such as "carrying around with you" and "something got you on an elastic band". In similar type of responses, metaphors were used to creatively describe clients' phenomenology and often contained action verbs to describe how the clients are relating to or experiencing their events, memories, feelings and so on. It was common to see descriptions like "weighing you down", "pulling you back" in this type of empathic responses. These responses targeted and referred to the implicit felt sense within the client on how they were experiencing their phenomenological world. It was observed that metaphors were sometimes used to describe the client or events instead of what clients were experiencing, and these metaphors were less facilitative compared to the ones described above.

On the other hand, the analysis found that responses were less facilitative when they tend to refer to events, behaviours or intellectual debate without referring to how the client was experiencing them, as illustrated in Exchange #02111.

Exchange #02111

C If I feel bad, I will instantly think I need some chocolate… I have a bad feeling because…I tried not to just stick to my habit of getting me some chocolate but it's…I get a craving when I feel bad, I don't have a plan of what to do.

T Is that you want to get rid of the comfort eating completely?

C I don't know what else would do to have the same effect…do you find something that comforts you that's not eating or do you just, find a way to just ignore it?

The exchange above illustrates how when the therapist's response referred to the behaviour of wanting to get rid of comfort eating, instead of referring to the sense of her "craving when she feels bad", the client's subsequent response continued to stay an external experiential orientation where she focused on finding a solution and even asked the therapist for advice. A more facilitate response that target the client's sense of how she experiencing her phenomenological world might be, "Whenever you feel bad, there is a sense of craving there to comfort yourself." This might facilitate the client to further explore that felt sense of having to comfort herself when she is down.

In summary, it was found that responses that specifically referred to the implicit felt sense of the clients could facilitate their involvement in their own experiencing. Such responses could be differentiated from less facilitative responses by how they specifically focus on how clients experience their phenomenological world, instead of the events, behaviours or feelings described in a brief, limited fashion. These responses often utilised metaphorical terms to describe how the clients might be relating to or experiencing their event, memories or feelings.

### 4.2.2 Allowing space for clients to explore their experiencing

Another helpful aspect of facilitative responses is how they give space for clients to derive their own meaning from their experiencing. These responses might use words like "something" or "sense" to refer to the implicit felt sense of the client, conveying a sense of tentativeness, without trying to grasp the meaning for the client. This is illustrated in Exchange #06101 below.

Exchange #06101

C From my perspective, it's easy to be become frustrated. I'm completely aware that it's not a quick fix, but…

T But it's still frustrating for you…*a bit like* trying to break through *something*.

C Yeah, I sort of feel like for me to know my own emotions, I have to break through a brick wall, but like for other people looking in to get through…it is like a bit more malleable to get through to find out how I'm feeling.

In the above example, we see the therapist did not try to explicate what is that "something" that the client was trying to break through. Rather, what the therapist seemed to be doing was to just gently refer to that "something" and being quite tentative about it by using the words "a bit like". In the client's subsequent response, he seemed to have a more differentiated symbolisation of his experiences, further expanding on the meaning of the frustration he was feeling.

On the other hand, responses were less facilitative when they consisted of long descriptions of the clients' experiences. These long descriptions appeared to be interpretations or explanations from the therapists and were found to be not helpful even if the therapist was using metaphors and attempting to describe phenomenology. This is illustrated in the exchange below.

Exchange #08107

C I think especially for me…because of my inclination to help people and look after people, it's not easy for me to say, "oh hang on, we shouldn't sort that out now." …it's a skill I need to work on, yeah, probably would be a challenge…

T You have the awareness…I almost have this image of a hellbent rescuer…seeing somebody standing there, and really needing help…and just jumps to be there with the person in need to help... You just jumped. That is empathy. You hear the person screaming and you go there as quick as possible. But before you jump, you just hold on a second, you're standing at the edge, you look down…it's like how? "What can I do to help this person?" …will yourself becomes a little bit damaged too because you jump? There needs awareness of how much can I give. How can I do it without hurting myself?... And I can take a different role in this entire thing, kind of stay with myself more rather than going completely in the position of the other person to help.

C Yeah, yeah. That's very true, very good analogy, good visual image.

In the exchange above, the client was beginning to recognise that she was inclined to help people and it was a challenge for her to hold off requests for help. However, the therapist's vivid description of the client's experiences left little room for this client to explore further on what that inclination to help people or this challenge might mean to her. As such, the client's involvement and exploration with her experiencing were apparently inhibited.

In summary, one helpful aspect of facilitative responses is that they engage the implicit felt sense of the client without trying to grasp knowledge or intellectualise it and allow clients to symbolise meanings of the felt sense on their own. Empathic responses are expressed in a tentative way as the therapists' intention is to check if their understanding was correct, and not to perform an accurate reflection of feelings (Rogers, 1986/1990). The clients could then check with their experiencing to confirm if therapists' understanding was correct and by doing so, they would have used their experiencing to symbolise more aspects of themselves.

### 4.2.3 Acknowledging immediate inner processes

The third helpful aspect of facilitative responses is the acknowledgement of inner processes, including the clients' feelings, experiences and internal struggles that were felt or expressed in the immediate moment. The lack of acknowledgement was a theme that reoccurred most frequently in the analysis of less facilitative responses, suggesting that it was one of the most important factors that accounts for bringing clients out of involvement from their experiencing. From the transcript analysis, there were three different ways that therapists missed out on acknowledging the client, and they are presented below.

Firstly, therapists missed out on acknowledging clients' inner process when they were asking for more information for clarity of external events before acknowledging the inner feelings that the clients have just expressed. This is illustrated in the example below:

Exchange #09407

C It feels more like uh, I'm devastated at the moment. I'm devastated because I couldn't be a male. Up until the point where I recognised it, I was going 22.

T Going 22… you mean last year?

C Uh yeah.

T So, it seemed like you noticed it was a long process for you then. Because you just noticed this when you were 22. Maybe…confused in terms of your identity before you were 22? And now it seems like, there is a big light there.

C Uh yeah…

In the above example, the therapist did not acknowledge the client's explicitly expressed feelings of how he was feeling devastated about his gender identity. The therapist first response was to ask for more information about when this happened for the client and this had nothing to do with the client's inner processes. In the therapist's next response, she was pointing out how client was confused by his gender identity, however, the therapist made no reference again to the client's feelings of being devastated. After this segment, the client was silent for more than 30 seconds before moving on to a totally different topic. In such instance, it was likely that the therapist has inhibited client's involvement in his experiencing.

Therapists might also miss the clients' inner process, meanings or symbolisation of experiences when they are trying to get deeper into clients' process. This is shown in Exchange #12103.

Exchange #12103

T Do you mean a lot of this anger and guilt all started coming out?

C It was explosive, yeah, and I think I probably didn't…

T What was that like?

C It just kind of reaffirmed my lack of self-belief and I was convinced that I was fucking the kids up, and I was shouting at them all the time, what an awful person I was.

T And how did that manifest itself? Was there a lot of crying?

C More shouting …just shouting and swearing and banging doors.

In the example above, we see that the therapist was initially describing the client's phenomenology and seemed to have acknowledged the client's emerging feelings of anger and guilt. The client then described that those feelings were "explosive". Without acknowledging it, the therapist continued to ask further to find out how it felt like for the client. The client then described some meanings of her experience about how she doubted herself and how awful she felt she was a person. However, these symbolisations of meanings were not acknowledged in that moment when the therapist continued to ask how those things manifested in the client. The client then focused on her behaviours, instead of exploring her experiencing further. This example has shown that it might be more facilitative for therapists to acknowledged clients' new symbolisations that were just expressed before attempting to direct process or ask more about process.

Another scenario of the lack of acknowledgement of clients' inner processes is when therapists come from their own frame of reference and provides their own interpretation. Exchange #08306 an example of this when the client was talking about her grief of two people she lost.

Exchange #08306

C When I wake up from my dream, I accepted it. I felt sad. Emotionally, it feels like there's a distance between me and the grief. Rather than being...being the grief.

T The grief was the connection you had with him over the last three years. So, what does that mean? If I grief in a different way, what would that mean? Would I lose the connection to her? Because what was left of him was this grief, so if I don't have that anymore, would I be less connected to him?

C Yeah. Feels like it's nearly 2 years, just grief and tears and missing. And learn not to…You had to let go, just accept it, and let go.

T It was the grief that kind of kept the memory alive, the grief that kept her alive.

C Yeah. And actually, memories still there with me, just don't need to hold on to it with grief and sadness. Let the grief go, still have the nice memories. Yeah.

In this exchange above, the client described that she was having more acceptance for her loss and feeling more distant from grief. However, this was not acknowledged by the therapist in the two subsequent speech turns as the therapist continued to interpret what this grief meant but did not respond to client's experience of acceptance and changing relationship with her grief. The client continued to express some elements of her acceptance in each of her speech turns and it seemed that the therapist's responses have not helped her to further explore her experiencing.

On the other hand, acknowledgement of the clients' expressed inner processes or the immediate symbolisations of new meanings can be very facilitative for the clients. This is evident in the III and EII responses which shows how acknowledgement plays a major contribution in maintaining clients' involvement in experiencing. The analysis shown that one important aspect that requires acknowledgement was when clients were starting to recognize an internal struggle. This does not refer

to struggles with external difficulties such as relationships problems or financial difficulties, but the struggles that lie within clients' inner processes that are beginning to symbolise into clients' awareness. Acknowledging these struggles may help to facilitate clients to symbolise these experiences further, while the lack of acknowledgement may inhibit clients from exploring it further. An example of a facilitative response is shown below:

Case #11102

C Generally, I'm pretty optimistic and kind of ambitious, I can really see that I can have potential. I know I have the potential to be an amazing poet and also be this really beautiful person. But it's down, like the nasty voices, so horrible and yeah…

T So it's kind of pushing apart, on one hand you see all of this, you see this potential, and you see what you could be…and yet this just wants to keep pulling you back and obviously, stamping on you.

C Even when I said I know I have that in me, the voices like, "you're not going to do anything about it, are you?" It's really cynical…I don't know how to make that go away, it's really deep, like the blackest core of my mind. And it's only mean to me, it doesn't expect that of other people.

In the exchange above, the therapist did not just acknowledge the client's feelings of optimism or just her experiences of the nasty voices. Rather, the therapists acknowledge that struggle between her optimism and the nasty voices and described the phenomenology of how this struggle was experienced by the client. The client's subsequent response showed a more differentiated symbolisation of the nasty voice in her.

Another aspect of acknowledgement in facilitative responses is when therapists recognise the implicit feelings that were hinted by clients' words or non-verbal expressions, as shown in the example below.

Exchange #02305

C We did talk about those things but not too much. I didn't say anything, just to kind of agree, I couldn't get out of it…

T You're… you're emotional now.

C (cries) I don't know why

T You're not sure why you're emotional.

C Here's just a situation that is very strange…we have this meeting to make sure I was doing well at work… and that sounds so positive. But we haven't addressed the other thing…about my appeal…And it just feels weird to me that she's pretending to be really nice and just ignoring it. And I have to kind of go along with that and be nice to her…but not mention that most important thing.

In the above exchange, it shows that the therapist was sensing the emotions that were possibly indicated by the client's tone or expression, and simply acknowledged that. This led to a catharsis of the client's emotions. The therapist continued to acknowledge the client's immediate experience of her not being able to understand her emotions. Subsequently, the client was able to explicate a situation further and symbolise her feelings of having her voice ignored. This exchange has shown that even simple acknowledgement of the client's immediate feelings could be very facilitative.

In summary, the qualitative analysis of the transcripts has shown the importance of acknowledging the inner process of the clients, especially the meanings, feelings or inner struggles that were expressed by the clients. It has also shown how acknowledging the implicit feelings as hinted by the client's non-verbal communication could be really helpful to facilitate involvement in experiencing. It is possible for therapists to miss acknowledging the client inner processes even when they are asking for clarification, attempting to direct clients' process or offering interpretations from their own frame of

reference. The data suggests the importance for therapists to first acknowledge expressed feelings and meanings of the clients before proceeding with other responses.

### 4.2.3 The Focus on Self Agency

The fourth helpful aspect that was found to facilitate clients' involvement in experiencing is the focus on the client's self-agency. Self-agency focused empathy are responses that identify the "sense of personal agency as they carry forward their experiencing" (Murphy et al, 2019, p.7). Lietaer and Gundrum (2018) also coined this as experiential selectivity where the therapists take the side of the actualizing aspects of the experiencing self. These responses usually refer to the client's self as an active force or as an actualizing tendency. There were two features in such responses. First, it would often contain the word "you" to refer to the client's self as the centre of their experiences. Secondly, it would also focus on what the clients were "doing" within their internal process. An example of this is shown below:

Exchange #06308

C I do feel like the barrier there… it has come down a lot, it's still there, and I think they always will. But they are a lot more… manageable today. And then…I do feel I made a lot of positive steps.

T You've protected yourself in the past by almost closing yourself off. You're now looking at how you can understand yourself in terms of protecting yourself but also keep that openness with other people around you, to feel better about your relationships.

C Yeah… I was always like this shy child. I won't speak to many people and definitely not about myself. When I was younger, I was in a rehabilitation programme and that sort of reinforced the fact that I have to keep myself closed in. I bottled things up as

a child. That's where my reaction sort of stem from, the programme I went to, I felt like I needed to do that more.

In the example above, the therapist empathised with the client's self-agency of wanting to both protect himself and also keep an openness with other people. This empathic response did not just respond to the presence of a barrier or how it had felt more manageable. The response described what the client was trying to do constructively and the actualizing direction that the client was moving towards to. The therapist also consistently used "you", referring to the client's agency in all this. The client's subsequent responses showed how she then arrived at more symbolisation of her experiences as she gained more understanding of why she had been bottling things up as a child.

In contrast, therapists' responses that focus on third-parties' behaviours, motivations or explanations without referring to how the clients' agency was found to be less facilitative and might have brought clients' out of their involvement with experiencing. An instance of this is illustrated below.

Exchange #05405

C It won't be long before they start making comments about how old you look, and I'm not able to deal with that, like I don't want any comments about what I look like.

T Yeah, almost like they've got no idea of the effect that they will have on you, or they just don't care.

C The thing is they do know, they don't know everything.

T So, they don't really care

C It makes them feel better I think.

In the example above, the client was initially describing her inner experiences of not being able to deal with negative comments. The therapist's responses described the intentions of other people and not how the client was experiencing them. Subsequently, the client turned to focus on these other people as well. While these responses may be an attempt to convey empathy to clients on how they are perceiving others, they take a risk of bringing clients out of involvement from their experiencing when they do not focus on the clients' agency. A possible self-agency empathic response in this context might be, "These comments feel so painful for you that you really wish to block them out."

## 5. Discussion

In the quantitative part of this research, it was found that that client's level of involvement with their experiencing is a phenomenon that could be observed with reasonable reliability via the measures of Experiencing Scale and Therapist Referent through the inter-rater reliability test. The data has also shown that therapists' empathic responses play a significant role in influencing the client's involvement with their experiencing, especially how a therapist's response that was based on the external experiential focus could bring the client out of involvement from their experiencing. The implications on practice is that when clients are referring to their own experiencing or inner referent to symbolise implicit feelings or meanings, it is paramount for therapists to stay with the empathic understanding of the phenomenological world of the client without stepping out of it, so as not to disrupt potential symbolisation of new meanings and feelings or curb actualizing directions that may emerge from clients being involved with their experiencing. To further specify what this means in therapy, a bottom-up inductive process based on phenomenology was used to identify what are the helpful elements in empathic responses.

The ratings have enabled a systematic way of doing the qualitative analysis as it helps to identify and differentiate the therapists' responses that are either helpful or unhelpful by the way they influence the clients to focus externally or internally. Through the qualitative analysis, we identified four helpful aspects of empathic responses. The first of these elements is referring to the clients' implicit felt sense, which is usually expressed as statements that describe how the clients are experiencing their world phenomenologically. Meanwhile, empathic responses that only refer to events, thoughts, behaviours, feelings without further elaboration on how clients experience them were observed to be less facilitative empathic responses. The second aspect is the giving of space for clients to derive their

own meanings from their experiencing in contrast to interpreting or explaining clients' experience in an attempt to convey empathic understanding. The third helpful aspect is the acknowledgement of the immediate inner process of the client, such as the feelings and inner struggles that were expressed by the clients or the implicit feelings that was communicated via non-verbal cues. Lastly, it is the focus on the client's self-agency as opposed to focusing on the intentions and behaviours of third parties that were brought up in conversation. Apart from the four aspects, one other interesting observation from the transcripts was that the same therapists tend to make the same types of unhelpful responses throughout all the four different time points. This highlights that clients were not solely responsible for maintaining similar experiential patterns throughout therapy as therapists also contributed to this. This observation suggests that there is potential for therapist to use similar methods of analysing transcripts in their own practice to identify how they might have inhibited clients' involvement in experiencing.

The study was set out to investigate phenomenologically how the "optimal client-centred response" (Gendlin, 1961, p.240) look like when they refer to and formulate the client's felt experiencing and the findings of the four aspects have provided an initial answer to this question, further specifying the meaning of empathic understanding in person-centred therapy. These four helpful aspects are not mutually exclusive and overlap each other. A single facilitative response could consist of all these four aspects. For example, a response that refers to the clients' implicit felt sense at that moment is also a response that is acknowledging the immediate inner process of the client. The identification of these four helpful aspects is not meant to be prescriptive or define what therapists should do in therapy. None of these elements is meant to be techniques or calling for therapists to take up the expert role to direct process. Rather, the purpose of identifying these elements is to aid therapists in having an expanded awareness of different aspects of the clients' experiencing and how some responses might be facilitating or inhibiting clients' involvement with experiencing. The four aspects are not additional conditions apart from the necessary and sufficient conditions of therapeutic change (Rogers, 1957) but are very much expressions of empathic understanding and unconditional positive regard. These four aspects are also consistent with the person-centred view of human beings where there is an "uncompromising trust" (Rogers, 1975, p.1843) in the growth process of individuals to be fully themselves. They can be helpful pointers for therapists to work with the phenomenological experiencing within client, denoting these phenomenological experiences as the highest authority within the clients

to derive their own meanings and determine their own directions. In other words, to facilitate the reconnection of clients to their own organismic valuing process.

This research is an abbreviated form of a new method called the comprehensive process analysis as adapted by Murphy *et al* (2019). While they used the method to identify key common principles of trauma-focused work in therapy by analysis transcripts of "good" and "poor" outcome cases, this research identified helpful aspects of therapists' responses by analysing facilitative and less-facilitative responses. This was only made possible by a systematic way of rating the transcripts using the EXP scales and converting the scores to internal and external experiential focus. The method has helped the research to go beyond just identifying how the experiential focus of the therapists' influence clients' involvement in experiencing but also helped to specify what are the elements of an "optimal client-centred responses" (Gendlin, 1961, p.240) that help to formulate the client's immediate felt experiencing as discussed at the beginning of this paper. It is a bottom-up method based on phenomenological analysis of actual therapy process rather than a top-down expert-driven approach to determine what is helpful in therapy. The pool of therapists featured in this study are all therapy trainees, thus, there may be an under-representation of experienced therapists that may provide more data on helpful aspects of therapists' response. However, this is also a strength of this study as using the transcripts of trainee therapists has helped to identify what might be the unhelpful behaviours that person-centred experiential therapists may make at the beginning of their career. It is the identification of the unhelpful elements that help to further differentiate what is helpful.

There are some limitations to this study. Firstly, it was very labour intensive to complete, review and analyse the transcripts. The sample pool was reduced from 40 to 25 midway through the study during the transcribing period and further reduced to 12 during the analysis of the transcripts. However, the completed transcripts can now be added to a pool of existing data within the HFP clinic to aid future research. Another limitation is the validity and reliability of the ratings. Although an inter-rater reliability test was done on a small sample with an expert rater, the validity of the rating may be improved when there is a second-rater to rate all the transcripts and also provide a second opinion on ratings through discussion. The ratings might also be affected by subjective bias as the rater, who was also the researcher, was not blind to the goals of the research. The experiencing scales also could not account for the context of the responses, for example a high scoring therapist's response in TR might be entirely unhelpful because it missed what the client was saying at that moment. The mitigating factor was that

the ratings were mainly used as a guide to identifying helpful or unhelpful responses instead of taken at their face value. The rigorous qualitative analysis would have hopefully overcome the effects of these shortcomings. The third limitation is that this study assumed that exchanges that were internally focused were more helpful and facilitative for the clients, without considering that some clients may find therapy helpful in other ways. Fourth, the study only considered the clients' immediate responses to therapists' empathic responses and hence it might have missed out clients' change process that was beyond that immediate moment of the exchange. Lastly, experiencing is only one variable in the therapy process and it is not the only factor that accounts for change. Variables like how the clients receive the facilitative conditions from the therapists were not considered. These are beyond the scope of this study and they are gaps that require further studies to fill.

Further research might be a replication of this study with an expanded scope using a larger sample size and transcripts of sessions done by experienced person-centred therapists to identify if there are other helpful aspects missed out in this study. The overall and sessional scores (see Appendix 3) from both the clients' and therapists' experiencing scale could also be analysed with other therapeutic variables such as the clients' experience of the therapeutic conditions as measured by the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1986) and the outcomes measures such as the Authenticity Scale (Wood, Linley, Maltby, Baliousis, & Joseph, 2008) and the Scales of General Well-Being (Longo, Coyne & Joseph, 2017). The data of the four time points are already available in the research clinic and can be used to investigate trends and relationships between EXP, relationship variables and outcomes. Lastly, while this study has attempted to specify how empathic understanding could be expressed by therapists, further studies could be done to investigate the phenomenology of how empathic understanding are received by the clients and use these findings to triangulate with the four helpful aspects identified in this study.

## 6. Conclusion

Based on the proposal by Rogers (1966) and Gendlin (1961) that the optimal client-centred response is one that facilitates clients to refer to their experiencing, this study was set out to investigate the relationship of therapists' responses and clients' experiencing. We have used the existing Experiencing Scales combined with a dichotomous coding method to identify relationships between

therapists' focus on clients' experiencing and the influence on clients' focus on their own experiencing. Four helpful aspects of facilitative therapists' responses were identified, and they provided further insight into how empathic understanding can be expressed in person-centred therapy. These aspects relate to therapists referring to the clients' implicit felt sense, allowing space for clients to derive their own meanings, acknowledging both expressed and implicit feelings or experiences in the immediate moment and focusing on the clients' self-agency. The richness of the data in transcripts have provided facilitative and less facilitative examples for each of these aspects and they seem to be relevant material for therapists in training. This study has provided evidence for the value of phenomenological research that is grounded in actual therapy processes, and more phenomenological studies on how clients receive expressions of empathic understanding could be done to triangulate with the findings of this study. Future studies can also be done with a wider scope of therapists' experience to explore if there are any other helpful aspects that are facilitative of experiencing.

# References


Adams, K. E. (2010). *Therapist influence on depressed clients' therapeutic experiencing and outcome* (Unpublished doctoral dissertation). York University, Toronto, ON.

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method and use. In L. S. Greenberg & W. M. Pinsof (Eds), *The psychotherapeutic process: A research handbook* (pp. 439-476). New York: Guilford Press.

Brodley, B. T. (1996). Empathic Understanding and feelings in client-centered therapy. *The Person-Centered Journal,* 3(1), 22-30.

Ebel, R. L. (1951). Estimation of the reliability of ratings. *Psychometrika*. 16(4), 407-424.

Gendlin, E.T. (1961). Experiencing: A variable in the process of therapeutic change. *American Journal of Psychotherapy, 15*(2), 233-245. From http://www.focusing.org/gendlin/docs/gol_2082.html

Hitz, L. C. (1994). *Effects of changes in experiencing level of therapist responses on client experiencing* (Unpublished doctoral dissertation). University of Arkansas, Fayetteville.

Jennen, M. G., Lietaer, G. & Rombauts, J. (1978) Relationship and interaction between therapist conditions (as perceived by client, therapist and outside judges), client depth of experiencing during therapy and constructive personality change in individual psychotherapy. Unpublished manuscript, University of Leuven, Belgium

Lietaer, G. & Gundrum, M. (2018) His master's voice: Carl Rogers' verbal response modes in therapy and demonstration sessions throughout his career. A quantitative analysis and some qualitative-clinical comments. *Person-Centered & Experiential Psychotherapies*, 17:4, 275-333.

Longo, Y., Coyne, I., & Joseph, S. (2017). The scales of general well-being. *Personality and Individual Differences*, 109, 148–159.

Mantel, N., and W. Haenszel. (1959) Statistical aspects of the analysis of data from retrospective studies of disease. *Journal of the National Cancer Institute*, 22: 719-748.

Murphy, D., Elliott, R., Carrick, Lorna. (2019) Identifying and developing therapeutic principles for trauma-focused work in person-centred and emotion-focused therapies. *Counselling and Psychotherapy Research.* 00, 1-11. doi:10.1002/capr.12235

Klein, M. H., Mathieu, P.L., Gendlin, E. T. & Kiesler, D. J. (1969) "The Experiencing Scale: A Research and Training Manual," Vol. 1, University of Wisconsin Extension Bureau of Audiovisual Instruction, Madison.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. S. Greenberg, & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 21-71). New York: Guilford.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.

Rogers, C.R. (1966). Client-centred therapy. In S. Arieti (Ed.), *American Handbook of Psychiatry* (Vol. 3) (pp. 183-200). New York: Basic Books.

Rogers, C. R., Gendlin, D. J., Kiesler, D. J., Traux, C.B. (Eds.). (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison: The University of Wisconsin Press.

Rogers, C. R. (1975). Client-Centered Psychotherapy. In H. I. Kaplan, B.J. Sadock and A.M. Freeman. (Eds.), *Comprehensive Textbook of Psychiatry II*. Baltimore, MD: Williams and Wilkins.

Rogers, C. R. (1980a). *A Way of Being*. Boston: Houghton Mifflin

Rogers, C. R. (1980b). Client-centered Psychotherapy. In H. I. Kaplan, A. M. Freedman, & B. J. Sadock (Eds.), *Comprehensive Textbook of Psychiatry III* (3rd ed., Vol. 2, pp. 2153–2168). Baltimore: Williams & Wilkins.

Rogers, C.R. (1986/1990). Reflection of feelings and transference. Person-Centered Review, 1(4),375–377 and 2(2), 182–188. Reprinted in H. Kirschenbaum & V. L. Henderson, *The Carl Rogers Reader* (pp. 127–134). Boston: Houghton Mifflin.

Wood, A.M., Linley, P.A., Maltby, J., Baliousis, M. and Joseph, S. (2008) The authentic personality: A theoretical and empirical conceptualization and the development of the Authenticity Scale. *Journal of Counseling Psychology*, 55(3): pp.385-399.

# Appendix 1

**Clients' Experiencing Scale**

Extracted from Klein, Mathieu-Coughlan & Kiesler, 1986, pp. 22-23

Stage 1

The chief characteristics of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvment is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings are avoided and personal involvement is absent from communication.

Stage 2

The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his or her interest us clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings, Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement.

Stage 3

The content is a narrative or a description of the speaker in external or behavioural terms with added comments on feelings or private experiences. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally.

Self-descriptions restricted to specific situations or roles are also part of Stage 3. Thus feelings and personal reactions come into clear but limited perspectives. They are "owned" but bypassed or rooted in external circumstance.

Stage 4

At Stage 4 the quality of involvement or "set" shifts to the speaker's attention to the subjective felt flow of experience as referent, rather than o events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal, internal perspectives or account of feelings about the self. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse, requiring the speaker to attempt to hold on to inner referents. By attending to and presenting this experiencing, the speaker communicates what is like to be him or her. These interior views are presented, listed, or described, but are not the focus for purposeful self-examination or elaboration.

Stage 5

The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: First, the speaker must pose or define a problem, proposition, or question about the self explicitly in terms of feelings or relate feelings to other

private processes. Second, the speaker must explore or work with the problem in a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner references that have the potential to expand the speaker's awareness of experiencing. These may also be evidence of and/or references to the process of groping or exploration itself.

Stage 6

At Stage 6 the way the person senses the inner referent is different. There is a felt sense of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. It is a sense of potentially more than can be immediately thought or named. This felt sense is more than recognizable feelings such as anger, joy, dear, sadness, or "that feeling of helplessness". If familiar or known feelings are present, there is also a sense of "more" that comes along with the identified feelings.

Stage 7

The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent t another, linking ad integrating each immediately nuance as it occurs in the present experiential moment, so that new sensing functions as a springboard for further exploration and elaboration.

# Appendix 2

**The Therapist Experiencing Scale (Therapist Referent only)**

Extracted from Klein, Mathieu-Coughlan & Kiesler, 1986, pp. 54-59

Stage 1

Referent: The therapist is referring to events that are external to or not about the patient.

Stage 2

Referent: The therapist refers to events including or involving the patient, with behavioural or intellectual elaboration of the patient's activities or thoughts, but these references do not refer to or define the patient's feelings.

Feelings and personal perspectives that may be apparent are still implicit, but not explicit. If the patient's feelings are mentioned, they are treated abstractly or impersonally as objects or are attributed to others. Third-person pronouns—for example, "one feels"—indicate this distancing.

Stage 3

Referent: The therapist refers to the patient's reactions to external events with some reference to feelings, but these are brief or limited to behavioural or descriptive comments. The results is a recognition of the patient's personal involvement without any detailed elaboration of the extent or quality of involvement. The patient's feelings are almost parenthetical; an event or idea is described, with the reference to the patient's feelings merely added.

Stage 4

Referent: The therapist refers to the patient's feelings and/or internal, personal perspectives. When events or situations are mentioned, it is only to provide context for the description of the patient's feelings and experiencing. Thus, the elaboration at this stage provides a clearer picture of what the patient is like as a person through a description of his or her feelings and phenomenology. The patient's feelings, motives, prior perception, goals, and so on are an integral part of therapist's concern.

Stage 5

Referent: The therapist invites the patient to explore and expand feelings and inner referents by stating a problem or proposition about them.

The questions and formulations are not simply intellectual; rather, they encourage the patient to actively struggle to explore and expand his or her experience.

Stage 6

Patient Referent: The therapist focuses on the patient's directly sensed, emergent, newly recognised, or more fully realised feelings and/or experiences.

As in Stage 5, the changes or the impact of changes must not just be recounted intellectually or abstractly; they must clearly be lived in the present moment.

Stage 7

Patient Referent: The therapist's focus is on the patient's potential or present facility to move from one inner referent to another. The patient's capacity to build upon, link, and integrate each new realisation on the former is noted or elaborated and fully shared.

# Appendix 3

**Clients' and Therapists' EXP Sessional Scores**

| Client's EXP Mod | | | | |
|---|---|---|---|---|
| Client No. | Session 1 | Session 4 | Session 9 | Session 14 |
| 1 | 5 | 4 | 4 | 3 |
| 2 | 2 | 3 | 3 | 2 |
| 3 | 3 | 2 | 3 | 3 |
| 4 | 3 | 4 | 3 | 3 |
| 5 | 3 | 3 | 3 | 2 |
| 6 | 3 | 3 | 4 | 4 |
| 7 | 4 | 4 | 5 | 4 |
| 8 | 3 | 3 | 3 | 2 |
| 9 | 3 | 2 | 2 | 3 |
| 10 | 3 | 2 | 4 | 2 |
| 11 | 5 | 3 | 4 | 3 |
| 12 | 4 | 3 | 4 | 4 |

| Client's EXP Peak | | | | |
|---|---|---|---|---|
| Client No. | Session 1 | Session 4 | Session 9 | Session 14 |
| 1 | 5 | 5 | 5 | 4 |
| 2 | 3 | 4 | 4 | 3 |
| 3 | 3 | 4 | 4 | 4 |
| 4 | 4 | 4 | 4 | 5 |
| 5 | 4 | 4 | 4 | 4 |
| 6 | 5 | 4 | 5 | 4 |
| 7 | 4 | 4 | 6 | 4 |
| 8 | 5 | 4 | 4 | 3 |
| 9 | 3 | 3 | 3 | 4 |
| 10 | 4 | 3 | 4 | 4 |
| 11 | 5 | 4 | 5 | 4 |
| 12 | 4 | 4 | 4 | 5 |

| Therapist Referent Mod | | | | |
|---|---|---|---|---|
| Client No. | Session 1 | Session 4 | Session 9 | Session 14 |
| 1 | 2 | 4 | 4 | 3 |
| 2 | 2 | 3 | 3 | 2 |
| 3 | 3 | 4 | 4 | 2 |
| 4 | 3 | 3 | 3 | 3 |
| 5 | 2 | 3 | 3 | 2 |
| 6 | 4 | 2 | 4 | 4 |
| 7 | 4 | 4 | 4 | 4 |
| 8 | 3 | 2 | 4 | 3 |
| 9 | 2 | 2 | 2 | 3 |
| 10 | 4 | 2 | 3 | 2 |
| 11 | 4 | 3 | 4 | 3 |
| 12 | 4 | 3 | 4 | 4 |

| Therapist Referent Peak | | | | |
|---|---|---|---|---|
| Client No. | Session 1 | Session 4 | Session 9 | Session 14 |
| 1 | 5 | 5 | 5 | 4 |
| 2 | 3 | 4 | 4 | 3 |
| 3 | 4 | 4 | 4 | 3 |
| 4 | 5 | 4 | 5 | 4 |
| 5 | 4 | 4 | 4 | 4 |
| 6 | 4 | 4 | 5 | 4 |
| 7 | 4 | 4 | 4 | 4 |
| 8 | 3 | 3 | 4 | 4 |
| 9 | 3 | 3 | 3 | 3 |
| 10 | 4 | 4 | 4 | 4 |
| 11 | 5 | 4 | 4 | 4 |
| 12 | 4 | 4 | 4 | 5 |