Client-Initiated Homework in Client-Centered Therapy

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This article explains the way homework is integrated into client-centered therapy (sometimes called person-centered therapy). It first presents a summary of the theory based on Carl R. Rogers’ therapeutic conditions (congruence, unconditional positive regard, and empathic understanding), emphasizing the importance of the nondirective attitude. It describes Rogers’ change theory based on unconditional positive regard and illustrates the therapeutic interaction process with segments of a typical session conducted by Rogers. Homework is then described and explained as almost always initiated by the client, with therapists’ responses that range from pure empathic following to occasionally providing suggestions and instructions. The results of a small survey of nondirective client-centered therapists concerning homework are summarized, and several client/therapist interactions relating to homework are described. Homework in client-centered therapy, when it does occur, is an outcome of clients’ initiatives and is consistent with the way the therapy fosters and protects clients’ autonomy, self-determination and their sense of self.

Client-centered, also termed “person-centered,” refers to Carl R. Rogers’ theories of psychotherapy, group process, personality development, development of disturbance, recovery from disturbance, marriage, education, and of relationships in general (Rogers, 1959, 1961, 1969, 1970, 1972, 1980, 1986a). All of these theories embody values of respect for the individual person, values of tolerant understanding toward persons, and the values of an egalitarian, mutual and democratic approach to relations between persons (Rogers, 1980; Brodley, 1996). Some contemporary therapists, practicing Rogers’ nondirective client-centered therapy, work with
clients who initiate homework. This paper will summarize the therapy theory, illustrate the practice with parts of a transcript, describe homework in client-centered therapy, give examples of clients initiating homework, and explain how it fits into the nondirective practice.

THE CLIENT-CENTERED THEORY OF PSYCHOTHERAPY

Rogers (1980) stated the central hypothesis of his approach as follows: “Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided” (p. 115).

These facilitative psychological attitudes provided by the therapist are congruence, unconditional positive regard, and empathic understanding of the client’s internal frame of reference. Inherent, although implicit, in these attitudes is the nondirective attitude (Bozarth, 2000, 2002; Brodley, 1997; 1999a; Merry & Brodley, 2002; Raskin, 1947). Together, these four attitudes define the main characteristics of client-centered therapists in relation to their clients. The attitudes determine therapists’ attitudes, influence therapists’ feelings about their clients, and shape all of their therapeutic behavior.

Rogers’ Therapeutic Conditions

Congruence refers to the inner integration and wholeness of the therapist. It results from a therapist’s own capacity for self-acceptance or unconditional self-regard (Bozarth, 1998a), from a capacity for cognitive-emotional complexity, and from a capacity for uncensored self-awareness. Congruence requires therapists to engage in subjective processes and in behaviors, such as consultation, that maintain the integration of their whole person. It is fundamental to therapists’ well-being in therapy and to their ability to maintain the client-centered therapeutic capabilities in the relationship. Congruence is expressed in the therapist’s presence (Baldwin, 1987; Brodley, 2000) as the qualities of genuineness, realness, and transparency. In this way, it is fundamental to the client’s perception of the therapist as authentic in communicating empathy and unconditional positive regard.

Unconditional positive regard (UPR) refers to the therapist’s acceptance, nonjudgmental caring, or unconditional prizing of the client (Bozarth & Wilkins, 2001). It involves the therapist in a nonjudgmental
acceptance of clients whatever clients are immediately communicating about their feelings, thoughts or actions. It involves accepting the person regardless of their actions or ideas, and it involves caring for the client regardless of the client’s differences from the therapist.

The attitude is expressed in the therapist’s presence as interpersonal warmth, and in the therapist’s nondirective empathic following of the client. Unconditional positive regard is not communicated explicitly; it is primarily implied by the absence of directions, interventions, and confrontations. The accepting, empathic following process is inherently free of the therapist’s judgments or conditional acceptance and consequently is likely to communicate the therapist’s unconditional positive regard (Brodley & Schneider, 2001) to clients. The client-centered therapist must develop a capacity for a mindset that is free of diagnostic categories, expectations, and prejudices concerning the client. This is necessary in order to be open to the whole client and to the client’s shifts and developments in the immediate moments of interaction.

Empathic understanding of the client’s internal frame of reference refers to an attitude that usually involves the therapist in deliberate verbal behavior. The therapist devotes full attention to the client and to the client’s immediate experiences and communications. Doing this, therapists try to accurately sense and understand the feelings and personal meanings that the client appears to be intending to communicate. Empathic understanding is not a single event. It is a process of interaction with clients. In the process, from time to time, client-centered therapists deliberately communicate responses based on their own subjectively experienced accepting empathic understanding. This is done in a tentative manner and is intended to check their understanding (Brodley, 1998; Rogers, 1986b). Consequently, clients are likely to perceive their therapist as trying to understand them, and they perceive empathic responses as invitations to correct any of the therapist’s misunderstandings and to go further in self-explication.

Successful communication to clients of unconditional positive regard and empathic understanding springs from therapists having assimilated these attitudes into their personalities. Therapists’ basic task is to experience the attitudes within themselves while in interaction with the client. The attitudes define therapists’ intentions, and their intentions shape all responses to their clients.

**The Nondirective Attitude**

The therapist with a nondirective attitude is constantly mindful to avoid deliberate—and even inadvertent—directing the clients’ attention to
content or processes that are determined by the therapist. With an empathic aim, the therapist follows clients’ intentions and accepts clients’ ways of communicating about their experiences. In this respect, client-centered therapy may be distinguished from a related therapy, experiential focusing therapy (Gendlin, 1996), a process-directive therapy that is based partly on Rogers’ client-centered theory. Because experiential therapists believe therapeutic changes occur through a high experientially focused client process (Hendricks, 2002), they attempt to focus clients onto their “felt sense” (Gendlin, 1978, pp. 32–40) if the client is not doing this spontaneously.

In contrast, the client-centered therapist views high experiential processes as not necessary or essential for therapeutic change. Although it does sometimes result from empathic understanding interactions, client-centered therapists do not intend, or even hope, to produce the focusing effect. They do not intend to produce any specific effect. They believe that directing clients, and thereby elevating the therapist to the role of an expert about the client’s process or content, is likely to undermine clients’ self-determination, their self-empowerment, and their psychological safety in the relationship. They agree with Rogers’ statements in an interview with Baldwin (1987) that good therapy requires that therapists not have goals for clients. Rogers said:

I think that if the therapist feels “I want to be as present to this person as possible, I want to really listen to what is going on. I want to be real in this relationship,” then these are suitable goals for the therapist. If the therapist is feeling, “I want this person to get over this neurotic behavior, I want this person to change in such and such a way,” I think that stands in the way of good therapy. (p. 47)

Therapeutic interactions imbued with the nondirective attitude permit and promote the client’s self-determination, autonomy, and a realistic sense of self that is based on “openness to experience” (Rogers, 1959, p. 206; 1961, pp. 187–188). Consistent nondirectivity is achieved by means of therapists’ constant nondirective intentions and their self-corrections.

The Client’s Perceptions

The therapeutic theory (Rogers, 1957, 1959) asserts that therapeutic change depends upon the therapist experiencing the therapeutic attitudes toward the client. Rogers hypothesized that the more fully and consistently the attitudes are present, the more therapeutic change is likely to occur. Additionally, the client must perceive or experience the therapist’s unconditional positive regard and empathic understanding for change to occur. Belief that the client must perceive or experience the therapeutic attitudes
orients the client-centered therapist to be sensitive, responsive, and accommodative to clients. Thus, therapists adapt to clients for the purpose of understandability. They modify their syntax, their vocabulary, the complexity of their speech, the pace of their speech, and their tone of voice, as well as more subtle features of their responses.

THE MECHANISM OF THERAPEUTIC CHANGE

Theoretically (Rogers, 1959), “conditions of worth” (pp. 209–210) are learned restrictions on a person’s awareness and limits his or her internal frame of reference. They result from conditional acceptance and disapproval by significant others in infancy and childhood, that has produced a distorted and limited self-concept, and an incomplete or distorted awareness of some of his experiences. When events occur—impinging from outside the person, or sensations or thoughts arising from within the person—that are inconsistent with these conditions of worth the person feels threatened and anxious. This is the basic predicament of clients suffering from psychological disturbances.

The mechanism of therapeutic change within the client involves a process of increasing self-acceptance, increasing acceptance of his or her subjective experiences, and an expansion and differentiation of the client’s internal frame of reference. This mechanism is stimulated primarily by the therapist’s attitude of unconditional positive regard within the totality of the therapeutic attitudes (Bozarth, 1998a; 1998b).

In the interpersonal situation of client-centered therapy, the therapist’s unconditional positive regard corrects for the interpersonal conditional regard that originally brought about the conditions of worth. The client becomes more “open to experience” (Rogers, 1961, p. 115) and less vulnerable and anxious.

THE INTERACTION PROCESS

The basic therapeutic situation usually consists of clients communicating by means of deliberate verbal narration and spontaneous expressive behavior about their inner experiences, life problems, and concerns. Client-centered therapists listen to understand these things from the client’s framework, and they articulate empathic understanding responses that are tentative representations of their inner empathic understanding in order to verify or correct it (Brodley, 1998; Rogers, 1986b). They try to express their responses in a manner that does not even inadvertently lead the client. Clients respond to the
therapist’s expression of empathic understandings by reflecting upon their own communicative intentions and by verifying, qualifying, or disagreeing with the therapist’s specific understandings. This usually stimulates them to go further in self-expression and self-representation. The back-and-forth between client and therapist becomes a constantly evolving interaction that clients lead, making their feelings and thoughts explicit, constantly modifying and elaborating them. Through this empathic understanding response process (Temaner, 1977), clients are able to discover new meanings and feelings and to experience their feelings more fully.

The following dialogue illustrates client-centered therapeutic interaction. The segments have been taken from a session conducted by Carl Rogers in 1983 (Merry, 1995). The dialogue starts near the beginning of the session.

**Client:** For a long time I felt like there is this big thing in me, and I don’t know what it is. (T: Mhm, mhm) And sometimes, when I hear other people talking, and it’s not so much the words they are using but it’s the feelings that I can sense in them, I feel heavy and I know that their feelings are touching (gestures toward her body) (T: Mhm, mhm) the same kind of feelings in me.

**Therapist:** They’re touching that secret part of you that you don’t quite know what it is. (C: Nodding) Mhm, mhm.

**Client:** Lots of times I sense hurt or pain. (T: mhm, mhm. mhm, mhm) sometimes it’s anger as well.

**Therapist:** That you feel whatever this is, that is sort of frightening within. . .is of negative feeling, the pain and hurt and, possibly, anger.

**Client:** Uhm, hmm (Nodding). And if I get in touch with them that they will overwhelm me. There’s a fear of getting lost in them somehow (T: Mhm, mhm). And not being able to find my way back to the joy that I can feel.

**Therapist:** Mhm, mhm. Mhm, mhm. That if you ever let yourself really live in or feel those feelings, maybe you’d never find your way back to pleasantness, and happiness and joy.

**Client:** (Nodding) ‘Cause I feel I can’t let go of things like hurt and I can’t let go of things like resentment. I want to let go of those things, but I don’t know how to do that (T: Mhm, mhm). So, I don’t want to explore them (T: Mhm, mhm). I feel that if I explore them, they will always be with me. (T: Mhm, mhm) And I’ve kind of learnt to experience joy (pause). I can say that to you, but I’m questioning whether or not joy is real (T: Mhm, mhm) now.

**Therapist:** Makes you wonder whether, maybe, the joy would be more real if you were able to explore some of those frightening feelings (Client: Nodding). (Pause 8 seconds) But they are scary.

**Client:** (Nodding) (Pause 6 seconds) I’ve put them away for such a long time, seems like.

**Therapist:** Mhm, mhm. Resentment and hurt and everything like that. You’ve kept it pushed down for a long, long time (C: Uhm, hmm). (Nodding)

The client continues talking with Rogers. She expresses her anger and
her hurt, describes what has happened to her, and she weeps. Later in the interview her fear becomes more immediate.

Client: I’m frightened now, because I feel like I might get lost in what it is I’m feeling and. . . (Pause 8 seconds)
Therapist: It’s scary to let yourself down into those feelings. You might not be able to get out.
Client: (Nodding) (Pause 15 seconds) It almost feels like self-pity and I don’t know if I can accept that (laughs), that I pity myself or I feel sorry for myself.
Therapist: Mhm, hmm. Mhm, hmm. You almost feel ashamed of that but you do feel sorry for yourself (C: Nods). You realize that, “I went through a hell of a lot” (C: Nodding). (Pause 10 seconds) “I really do feel pity for myself.”

Client: (Pause 8 seconds) I’ve washed it away now (both client and therapist laugh).
(Pause) I’m thinking about that time. It was in the Home and they used to say things like that. “You’ve always got this thing about pitying yourself. You should think about other people.” And, it was so much around me at that time. I think I’ve really learned it very well.
Therapist: You just don’t think things like that. “You should think about other people” (C: Nodding). And, “There’s a good lesson in sitting on your feelings.”
Client: (Nodding) It wasn’t such a good lesson.
Therapist: You learned it all too well.
Client: Yeah. It wasn’t such a good lesson. I know that.
Therapist: A strong lesson.
Client: (Nodding) I feel good because, I somehow feel I’m beginning to feel these feelings (T: Mhm, hmm). To talk about it. . .they’re coming out a little bit at a time. (T: Mhm, hmm, Mhm, hmm).

Five responses later, including thoughtful pauses, her feelings change again.

Client: Right at the moment I don’t feel as frightened as I did. . .although I’m sure that that might come back (T: Mhm, hmm). That feeling.
Therapist: But for the moment, they don’t seem quite so scary.
Client: (Nods) Now it feels like such relief because. . .I just think of all the times I meet people and the fear is there (T: Mhm, hmm). How much it stops me from being with people sometimes.
Therapist: Mhm, hmm. It’s really good to have that fear lessened a little where when it’s really stopped you from so many things.
Client: (Nodding) (Pause 36 seconds) And I think I’m also getting the feeling, “What’s so bad about telling other people that I’m hurt?”
Therapist: Mhm, mhm, Mhm, mhm. “What’s the big deal, what’s the big crime in saying ‘I’m hurt. I am hurting’?” (C: Nodding) (Pause) “Why does that seem so hard?” Umm. . .
Client: (Nodding) (Pause 6 seconds) And it has been difficult.
Therapist: It seemed really hard.
Client: (Nodding) (Pause 8 seconds) I think perhaps because I was trying to be somebody else (T: Uhmm). (Pause 7 seconds)
Therapist: Mhm, hmm, Mhm, hmm (Nodding). Trying to be someone that you were not.

Client: (Nodding) (Pause 6 seconds) Trying to be what other people wanted me to be, I think. (T: Ahh. Mhm, mhm, Mhm, mhm.) I think it’s all part of them not considering me (T: Mhm, mhm) and considering other people. What it is they want (Rogers: Mhm, mhm) from me. How they want me to be.

Therapist: Mhm, mhm. So “I’ve got to be what they would like, and not consider me.”

Client: (Nodding) (Pause 10 seconds) I think I’ll be me for a while (smiles).

Rogers’ close following, his empathic understanding, and his acceptance make the therapist the client’s companion (Natiello, 1994), as she tells him about her experiences and her emotional pain. The dialogue illustrates the therapist’s intention to follow the client’s feelings and perceptions without having any goal to change the client’s state or give the client a structure or meanings other than those the client seems to be expressing. The nondirective character of client-centered therapy is obvious in Rogers’ responses, although his empathic responses are not a parroting of his client’s words.

Understanding in therapy requires inference and interpretation because spoken language, especially in personal exploration, is usually an approximation of a speaker’s expressive intentions. Thus, Rogers interprets his client’s meanings, but not from a theoretical framework. His interpretive intention is to grasp the meaning the client intends to communicate. With only rare and unsystematic exceptions, Rogers does not make responses in order to change the client’s meanings, or to reassure the client, or to alleviate the client’s pain, or to explore her feelings, or to explain the client to herself, or to change the client’s focus or manner of expression in any way. He is trying to understand and his client is the judge of Rogers’ accuracy.

Client-centered therapists intend to enter the client’s world, and consequently their attention is fully on the client. In this example, Rogers maintains a profound acceptant attitude toward the client and, partly in the client’s own words, empathically and closely follows the self-narrating client who is exploring her subjective world. The therapist so engaged is living the nondirective attitude, and as Raskin wrote in 1947, “in struggling to do this, there is simply no room for any other type of counselor activity or attitude” (quoted in Rogers, 1951, p. 29).

HOMEWORK IN CLIENT-CENTERED THERAPY

Homework in psychotherapy usually connotes a task or procedure that the therapist systematically introduces to the client for the client to perform or practice between sessions. The therapist expects the client to do
between-session practice, and report back about it. The therapist monitors and modifies the task as part of treatment. Homework assignments in therapies that employ them are a technique to advance the therapist’s goals for clients.

Client-centered therapists do not have goals for their clients; consequently they do not employ techniques (Bozarth, 1996). The therapy is an expressive therapy (Brodley, 2002); it is not an instrumental therapy in which means are employed to achieve ends. Client-centered therapists’ behaviors, of course, may be studied from the perspective of techniques since any behavior that is determined by values and attitudes may be examined as technique (Brodley & Brody, 1996). Nevertheless, objective analysis of the features of a therapy is not the same thing as understanding therapists’ intentions in their interaction with clients. Values, attitudes, and intentions determine therapists’ behaviors and also determine the qualities of the relationship. Disclaiming techniques, client-centered therapists do not intend or experience their responses as means to specific ends. Thus, it would seem that client-centered homework is an oxymoron.

Client-centered therapy is totally oriented toward receiving the client and being responsive to the individual client. It is oriented toward accepting the unique qualities of the relationship offered by individual clients. There is no role for any kind of diagnosis (except perhaps for purposes of referral to medical or psychiatric resources) or any kind of classification of clients or of their problems. There is no role for therapist-designed treatment plans. Client-centered therapists’ behaviors in relation to clients result from their attitudes and values and from their whole selves, including their bodily feeling life (Gendlin, 1991; Todres, 1999). These values, attitudes, and feelings are spontaneously expressed in therapeutic interactions such that they form a specific kind of relationship that minimizes the structural inequality between therapist and client, and minimizes the development in clients of illusions that a therapist is an expert about the client.

Client-centered therapy provides a distinctive context for homework. Client-centered therapists do not conceptualize their therapy as a treatment. They rarely make suggestions of any kind (Tomlinson & Whitney, 1970; Brodley, 1999a). They do not monitor their clients’ behavior because they are concerned to avoid behaving in any way that might shift the client’s “locus of evaluation” (Raskin, 1952; Rogers, 1959, p. 210) away from the client or toward the therapist. Monitoring also may distract the therapist from focus on the client’s frame of reference. Nevertheless, some clients of some client-centered therapists choose to engage in homework and to interact with their therapists about homework experiences as part of their therapeutic path.
I estimate that 15% to 20% percent of all my clients, in over 45 years of practice, have initiated homework, that is, specific tasks or activities that they have deliberately practiced outside of therapy sessions to assist them reach a self-determined goal and that they have talked about in subsequent sessions.

Over the years, clients have engaged in many different kinds of homework tasks. Some clients chose activities to help themselves feel more integrated or more relaxed and less stressed: meditation, slow deep breathing and relaxation techniques, Yoga lessons, massage therapy sessions, daily prayers, sessions with a hypnotist, and trance sessions with a shaman. Some clients felt a need for techniques to alleviate anxiety or panic attacks. They have practiced cognitive or behavioral procedures that I have suggested, or practiced techniques they read about in self-help books. Pregnant clients have practiced birthing techniques after discussing them in sessions. Some clients, to improve their physical health, have used parts of sessions to plan specific balanced menus for each day between sessions. For health reasons, others have planned steps for curtailing their use of, or steps for withdrawing from, cigarettes, cocaine, heroin, alcohol and other substances. Some clients have wanted to increase their physical strength or agility and made plans in sessions to engage in weight training, stretching exercises, dance lessons, swimming, tennis practice, training for marathons, and long walks.

Many clients have designed between-session intellectual activities, such as reading newspapers to become more aware of current events, systematic study of a particular kind of literature, such as poetry, to stimulate their imaginative processes, or philosophy to gain perspective on personal issues. Others have read books on how to improve relationships or about religious or spiritual matters and discussed them in subsequent sessions. Other forms of self-initiated homework have included writing journals, recording dreams, recording situations that arouse anxiety, and writing down fantasies. A few clients decided to draw pictures of very painful or unspeakable experiences and bring them to sessions. Some clients have used homework to improve their sexual lives by masturbating, creating sexual fantasies to employ in intercourse, or practicing specific sexual intercourse techniques. A frequent purpose for homework has been to improve interpersonal relationships with partners, parents, children and friends by talking to them about feelings, or practicing interpersonal techniques of listening, self-representation, and empathic responding. Several clients have worked on becoming aware of their judgmental reactions in order to be more accepting and kinder toward love ones, and one client attended an anger management clinic between sessions.

Typically, clients have brought their homework materials or experiences into subsequent therapy sessions for discussion or illustration. Fre-
quently, although not always, clients have felt their homework experiences helped them to feel better, to function better, and to move closer to their specific personal therapeutic goals. It cannot be overemphasized that these “homework” practices were always self-selected, that they expressed the clients’ self-direction and autonomy in our relationship, and that they were perceived within the sense we shared of being collaborators in the client’s change process. The major benefits in client-initiated homework have appeared to me to be not so much the homework activity itself, but the empowering effects of its self-initiation and its contribution to the clients’ feelings of freedom from surveillance and evaluation by an authority figure, thereby promoting clients’ utilization of their own capacities.

In order to gain a picture of other therapists’ experiences with clients doing homework, I asked, via email, 10 persons\(^1\) from the United States, England, Denmark, and Peru, who describe themselves as nondirective client-centered or person-centered therapists, about their experiences of clients doing homework. All the respondents, except an intern in a doctoral program, were therapists with many years experience as counselors or therapists. The therapists’ descriptions of their experiences emphasized their nondirective attitudes in relation to the homework. Two of the 10 therapists reported rare instances of suggesting a homework task, and in those cases the clients had given some kind of indication they felt such an interest or need.

As was the case in my experience with homework, the responding therapists reported that homework almost always occurs in client-centered therapy when clients initiate the idea of a technique, procedure or activity—something to do that might facilitate one of their goals in therapy. In all cases, the therapist, in the usual manner of client-centered work, intends to be empathically responsive to the client’s interest in homework but nonevaluative about it. These therapists, typical of nondirective client-centered therapists, are mindful to not become invested in the homework task or its outcome, remaining neutral to its value and the clients’ involvement in the task, while being responsive to the client as a self-determining person.

Some therapists respond only empathically, with the exception of addressing clients’ informational questions, when their client suggests doing some homework. They accept the client’s wish or intention, but do not

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participate by offering any suggestions, and do not provide instructions. They may, instead, refer the client to other professionals or resources in the community that are designed to meet the client’s requests (such as psychiatrists, cognitive–behavioral therapists, hypnotists, etc.). When they make a referral, usually the client continues working with the client-centered therapist, while engaging the services of the other professional.

Some therapists have adopted the view that if a client is making a request, or asking a question, they should be open to addressing the client’s request and open to accommodating to the request if they have the knowledge to do so (Brodley, 1999b). These therapists consider this adaptive responsiveness to clients an implication of the nondirective attitude. The idea is that the nondirective attitude includes respecting and following the person’s voice (Grant, 1990) within a therapists’ limitations. Therapists maintain the basic acceptant and empathic attitudes, however, whenever they communicate from their own frame of reference. On the basis of this interpretation of the nondirective attitude, some client-centered therapists not only engage in empathic understanding when asked about homework, but also offer specific suggestions about tasks that might forward the client’s goal. They also may give specific instructions for tasks in the context of clients’ requests, but they always intend to maintain their warmth toward the client, their neutrality about the desirability of the tasks, and explicitly inform their client they have no expectations about what the client will do in respect to the homework ideas discussed.

Some therapists may initiate a suggestion that the client employ a distress-relieving or pain-relieving task that requires homework. This is rare behavior for nondirective therapists and occurs usually in the context of a client acutely suffering. One of my nondirective respondents gave an instance of initiating homework with her client. She wrote:

A client was having a panic attack on the phone with me. I asked her if she would like me to help her brainstorm things she could do to help calm herself down. She said she was having a hard time retaining her thoughts, and I said I would help her with that. She agreed. Some of the things I suggested were things that I had found soothing or had heard others found soothing. Some of them I elicited from her through questions. Toward the end, one of the things we came up with she said she really liked, and since she had a plan to deal with her anxiety, she felt able to get off the phone and do that. Later I asked her whether this had been effective, not to check up on her, but because I had another anxious client and was wondering if this idea was helpful. (I told her this was why I was asking.) She reported it had been helpful. (I. Ehrbar, personal communication, June 18, 2001)

Even in the context of pain or desperation, however, therapists rarely suggest such techniques to their clients because they have found that heartfelt, consistent, and acceptant empathic understanding is the most helpful manner of response in such circumstances. Rogers expressed this
view in a 1986 interview, saying, “When the situation is most difficult, that’s when a client-centered approach is most needed and...what is needed there is a deepening of the [therapeutic attitudes] and not trying something more technique-oriented” (Rogers & Russell, 2002, p. 258).

Jerold Bozarth (personal communication, January 16, 2002) suggests caution in referring to “homework.” He is concerned that terming clients’ between-sessions activities as “homework” misrepresents client-centered therapy. Bozarth writes:

I consider the concept of “homework” another incursion of behaviorism into the principles of client-centered therapy. I don’t like using the term because it implicitly suggests that the client-centered therapist is up to something other than unconditional empathic reception. The idea promotes the therapy as a problem oriented therapy rather than focused upon therapeutic personality change that in turn allows the client to resolve her own problems. The concept of homework misses the essence of CCT. An act of homework is thus somewhat irrelevant to me. Many client out-of-session actions emerge from client-centered therapy including some that look like homework.

I share Bozarth’s concern, and acknowledge that using the term “homework” in client-centered therapy can be considered a stretch. “Homework” in client-centered therapy modifies the usual definition of homework in many respects, but principally by rejecting the idea of an assignment by a figure in authority. “Homework,” borrowing from Bozarth above, is between-sessions action that emerges from therapy and is usually further discussed during therapy.

EXAMPLES OF CLIENT-INITIATED HOMEWORK

The nondirective principle in client-centered therapy (trusting in the efficacy of the client’s manner of proceeding in therapy and the therapist having no goals for clients as part of his or her intentions in therapy interactions) precludes systematic homework assignments and makes it extremely unlikely that the therapist would initiate homework. But the very same principle promotes the therapist’s acceptance of clients’ initiations of homework and responsiveness to clients’ ideas about homework tasks.

An interaction from a session illustrates the way homework most frequently comes up in client-centered therapy. The client has been talking about events in his marriage that stimulate his anger at his wife. Then he shifts to expressing his fear of having accidents with his car or in his job and his fears that he is hurting his children and losing his marriage. He talks about how his angry outbursts are driving his wife away from him and how his use of alcohol contributes to the outbursts. He goes on.
Client: I’ve got to admit it, I get drunk and I’m a bastard to her. I’ve scared the kids. (Pause 10 seconds.) I’ve got to stop drinking. I’m out of control and I’m killing myself.

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

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

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

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

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

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

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

The client continues talking about the risks he takes and about his remorse. He starts the next session spontaneously reporting on the action he has taken the initial steps to get into a self-help group.

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

Therapist: Mhm, hmm. You’re doing something, not just talking (Pause). That feels better.

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

In the dialogue, the therapist responded empathically and offered no explicit support, guidance, or approval for the client’s plan, or for his having done what he said he was going to do, or for his intention to continue. Empathic understanding tends to be supportive of the person in the process of planning homework. Subsequently, the client did join an AA group, got a sponsor, and stopped using alcohol. His depression and the angry outbursts diminished. He reported that he felt less reactive to annoyances, more tolerant of his children’s misbehaviors, and more tolerant of petty differences with his wife. Discontinuing his use of alcohol also improved his sleep, his sexual potency, and he thought it helped him be more attuned to his wife’s needs.
Sometimes a client initiates homework and gains therapeutically simply from the attempt to practice. A client in a long-term lesbian relationship had been talking about how she and her partner were getting along.

Client: We’ve lost our passion. At least, all that’s left on my side is a warm, kind of fuzzy, affection for her (Pause). She’s more disappointed about it than I am. I’m always so tired. I have constant pain in my legs, I’m completely out of shape, I’m overweight, as you can see (Pause). I don’t even care about not having sex, or rarely having it. But she’s complaining; she’s unhappy about it (sighs).

Therapist: No passion, no sex—doesn’t feel bad to you. What pulls you down is your pain and tiredness, and feeling so out of shape. Except you realize that [your partner] is pretty miserable.

Client: Yeah. I do feel bad about her frustration and her disappointment and if I stop to think about it, it maybe doesn’t have to be this way, at least not so much. I make poor choices.

Therapist: Bad as you feel for her, you’re not doing what you could to make it better.

Client: Oh, yeah. I really think so. (Long pause) I can see how I indulge myself at her expense. How I stay up late watching TV to relax, instead of getting into bed with her. If I just put myself close to her and held her instead of giving in to my inertia, there’d be a chance for some intimacy.

Therapist: You give in to your tiredness. In the process you deprive both of you of some intimacy. Really, it wouldn’t be that hard to make things better.

Client: (Long pause) I want to try something. Every night when I get home early enough, instead of watching the TV, I’m going to get into bed next to her before she’s asleep. Maybe I’ll just hold her and see how that goes.

In the next session she told what had happened.

Client: I remembered, but I couldn’t get myself to do it. I realized that the idea made me angry at her, even though she didn’t even know about my plan. I realized how resentful I feel that I work so hard, harder than she does, and she makes demands on me that aren’t fair. I’m really angry at her and I think I’m punishing her.

The client decided to invite her partner into sessions for some couple work because she didn’t trust she could talk constructively about her resentful feelings without help. They came together for several sessions and resolved that they needed to make some changes in their living and working patterns that could alleviate the tensions they realized existed between them. Their plans worked for them and, among other things, resulted in more sexual interaction. This example exhibits how the client, initiating and orienting herself to a homework task, can find out something of importance simply by facing the homework, thereby promoting a therapeutic process and change. Among other benefits of clients choosing the
idea and specific tasks of homework, is that when it turns out to be unsatisfactory for whatever reason, clients tend to turn more immediately to their own thoughts and feelings in the experience rather than focus on the therapist’s role in the plan.

Another homework example illustrates the therapist’s accommodation to a client’s general request by giving the client choices and instructions. The client has suffered from anxiety and occasional panic attacks for years. Antianxiety medications have helped him somewhat. The psychotherapy has helped him explore psychological and situational causes of his anxiety. In a session, he brings up an idea his psychiatrist has suggested about learning a technique.

Client: The meds aren’t doing enough. I get into a panic and I can’t even see how it is connected to anything I’m doing or thinking about. A terrible anxiety just wells up inside me. (T: Mhm, hmm) (Pause three seconds) I was wondering (Pause). [Dr Burke] said you might have some techniques that could help me.

Therapist: Mhm, hmm. You still get terribly anxious and it completely gets its way with you. (C: Oh, Yeah. It really does.) So you wonder if I might know some things you might do to calm yourself when it happens.

Client: Yeah. Do you know what he’s talking about? (T: Uhm, hmm, nodding) He said there are things anybody can learn, and I might feel better with it, along with the meds and the therapy.

Therapist: Yeah, there are some techniques one can learn that sometimes help. I’m not expert in those things, but I know some of the procedures.

Client: Can you teach them to me? (T: Sure. . .) I’ll do anything not to be so anxious.

It’s awful (Pause). Sometimes I can’t stand it!

Therapist: You feel so terrible (Pause). You’re open to anything (C: I am.). Do you want to think about it more or try something right now?

Client: Let’s try it now.

I told him about several techniques he might use. The client chose the one that sounded easiest to him, and I gave a brief description of a breathing and relaxation exercise he could do when his anxiety starts to surge. I also explained the importance of practice to gain the skill and get a benefit. The client practiced the instructions in the session and said that he would practice more at home. In later sessions, he reported he was continuing to practice and use the technique. He felt the technique helped him. He felt more in control of himself and not so frightened of the anxiety attacks, which he said diminished in intensity.

Clients’ self-initiated homework tasks sometimes contribute to their self-determined therapeutic process when the client becomes distressed about the homework experience itself. In the accepting context of client-centered therapy, clients tend to feel free to consider engaging in activities they might otherwise avoid. One of my clients, for example, told me she had suffered from “trichotillomania”— compulsively pulling out her hair—off and on since childhood, had a bald spot from it, felt humiliated by her
behavior and her appearance, and she was very critical of herself for the behavior—calling herself “self-destructive” and “stubborn.”

The client, several years before, had read about using paradoxical intentional behavior as a technique for stopping bad habits. After a few months of therapy, she mentioned the idea of homework in a session, described her understanding of the paradoxical technique, and explained her hesitation because of her fears about exacerbating the symptom.

The client spent part of a few sessions discussing the idea of employing the technique as homework, and then she asked for my opinion about using it. I told her I had read about it as sometimes effective, but I had no idea whether it would help her stop pulling out her hair. In my remarks, I did not intend to encourage her or discourage her, but I did express the opinion that using any technique for therapy should be viewed as an experiment. I explained my idea of an experiment as something one might try in a very deliberate manner, going a step at a time, observing one’s feelings about it, and any apparent effects. She made a plan to deliberately pull out 1 hair every day and discuss the experience in our next session.

She called me two days later and asked for telephone time. She explained she had engaged in her usual form of unconscious twisting, and pulling out of hairs, but when she tried to sit in front of a mirror, as she had planned, in order to deliberately pull out a hair, she was unable to do it. She felt paralyzed and anxious, almost panicky, so she withdrew from the task, distracted herself, and calmed down. The next day she tried again and had the same experience.

She told me she was disturbed but also excited about the impact of trying the technique and amazed that she could not deliberately do what she had been doing automatically for years. She explained that she then realized she did not want to pull out her hair, that it was not something that she had ever wanted to do, that she had been blaming herself in part because she had taken on the “naughty girl” judgments imposed by her parents in childhood. She was tearful talking about the hurt she felt as a child from the judgments and expressed sorrow for herself and for her self-punishing attitude about her symptom.

The client did not understand why she engaged in the hair-pulling behavior any better than she had understood it before the homework experiment, but she said she felt more sympathetic toward herself. This client became more self-accepting, less moody, and felt more confident as a parent, but she did not talk about her hair-pulling after that telephone session other than to later mention that it had ceased.

Client-centered therapists usually do not ask their clients about problems or symptoms they have previously discussed. Often clients’ serious concerns are dropped as a topic, while the process of change exists beyond the therapist’s observations, sometimes to be mentioned later as resolved.
In this case, it appeared that the client’s version of a paradoxical technique for homework, much as it had disturbed her when she tried it, had played a role in her therapeutic process.

Another client, a married woman in her 30s described, at first with great difficulty and hesitance, a pattern of sexual behavior that was uncomfortable for her, but that she felt compelled to participate in. She explained that groups of couples in her neighborhood set up sex parties in their homes, at which three or four couples smoked marijuana, had intercourse more or less in front of the others with their spouses, and the husbands put pressure on their wives to have sex with the other husbands. She felt that as was true with most matters, she had to comply with her husband’s demands. She described herself as morbidly depressed, angry with her husband, feeling hopeless and a sense of loss of meaning in her life, and unable to refuse participation in the sexual activities. She said she loved her husband, depended on him economically, and feared he would leave her if she did not comply with his wishes. She felt guilty about the pleasure she felt having intercourse with the other men. She was aware of a sense of danger for herself because she was developing feelings of self-hatred and thoughts of self-destructive behavior.

After several sessions at first having the tenor of confession, she said she wanted to practice saying “no” to her husband. She felt her pattern of compliance with his wishes was so set that she could not resist her husband without support, so she decided she would try to engage one of the other wives who had confided her reservations about the sex parties, in role-play—imagining saying “no” to their husbands. The client spent part of a series of sessions discussing her progress in persuading her friend to resist their husbands and then about doing role-play practice together. She felt their discussions and the role-playing heightened her awareness of the problems in her marriage and strengthened her resolve to change her behavior. Her friend joined her in her determination to get more influence in their marriages.

After several weeks of talking about their patterns of subservience and practice using role-play, they planned to start being more assertive with their husbands in small matters. The husbands reacted with hostility to their wives’ unusual resistance, and her friend was unable to follow their plan to persist with her husband. The client, however, felt she had passed a point of no return. She continued to assert herself in the marriage and persuaded her husband to attend couple therapy while she continued her individual sessions. She felt the role-play, as well as the support from her friend while it lasted, helped her change the course of her marriage. Meanwhile she used her individual therapy sessions to build self-understanding about her susceptibility to domination and to extend her assertiveness to other relationships. This case illustrates the way self-initiated
and self-designed homework becomes part of a larger pattern of clients’ out-of-session actions that appear to be crucial in their personal change.

**SUMMARY**

Perhaps all clients engage in activities between sessions that foster their therapeutic change, but only a relatively small proportion of client-centered therapists’ clients choose to engage in tasks that resemble traditional homework. When it happens, homework enters client-centered relationships in 3 different ways. The most frequent is when the client states the intention to do something or practice an activity between sessions, thinking or hoping to forward a specific therapeutic goal. The client initiates discussion with the therapist about the activity or its benefits and decides to practice the activity. The client chooses whether to discuss the homework in subsequent sessions. In this most frequent form, the homework idea and discussions about it are totally initiated by the client and the therapist’s responses are almost exclusively those that express empathic understanding.

A second way homework occurs is when the client asks the therapist for ideas or help for doing between-session goal-directed activity. Clients usually ask for this help because they feel an urgency to alleviate a specific symptom or improve a problematic situation, such as frequent arguments with a spouse. This scenario varies, but it usually includes the therapist both in empathic following the client as she or he narrates, and in making some responses from the therapist’s frame of reference that address the client’s question. These responses may include ideas and descriptions of activities, or instructions for the practice. The therapist’s responses from the therapist’s frame of reference maintain the basic empathic, acceptant, and nondirective attitudes in their tentativeness, their sensitivity to the client’s internal frame of reference, and their attunement to the client’s goal.

The least frequent situation that brings homework into the client-centered relationship is when the therapist moves to initiate a suggestion for some activity the client might do between sessions. Therapist initiation of a task is usually to ease the client’s acute emotional suffering. In most cases, even when a client’s suffering is urgent or extreme, the therapist primarily interacts with the client through the empathic understanding process, following the client’s representation and expression of experiences as closely as possible. To emphasize—client-centered therapists are unlikely to initiate suggestions, they never attempt to persuade a client to take on homework, and they avoid personal investment in tasks and outcome.
On the rare occasions when they do offer a suggestion, it is most likely in a developed relationship—one in which they have grounds to feel a trust that the client will not misunderstand their intentions as expectations or investments in outcome.

The integration of homework, in the manner I have described, into client-centered therapy is a natural and spontaneous result of therapists’ nondirective attitude, their acceptant and empathic attitudes, and their empathic following behavior in response to whatever clients are expressing to their therapist. Client-centered therapists do not expect their clients to engage in homework, but if their clients wish that kind of help, such therapists are responsive to this expression of the client’s self-determination without promoting the idea that the therapist has homework expectations or inclinations to monitor the client. Therapists have observed that their clients who engage in homework tend not to change their basic sense of the therapist. Like their other clients, they respond to the therapist with increasing evidence of their autonomy, tending to become free of expectations that the therapist function as a locus of evaluation for them. The therapists feel they remain consistent in their values—as a genuine person who accepts the client, who is consistently empathic, and who remains nondirective. Either this is what homework is in client-centered therapy, or there is no homework in client-centered therapy.

REFERENCES


Chicago Counseling and Psychotherapy Center.

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