Conditions That Create Therapeutic Connection: A Phenomenological Study

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In this phenomenological study, counselor and client participants \((N = 14)\) described the conditions that fostered meaningful therapeutic connections. Among all participants, consistent descriptors appeared that were rigorously synthesized into a detailed depiction of therapeutic contact.

Keywords: counseling, therapeutic connection, healing, phenomenological

Although many counseling and psychological theories propose humanistic and phenomenological therapeutic techniques, words to describe the therapeutic connection between counselor and client remain vague. The counselor’s act of acceptance of the client’s emotional pain and internal experience is an anecdotally understood curative factor (Rogers, 1995), but in the age of managed care, the debate continues over whether it is both necessary and sufficient. Factors within the therapeutic relationship such as unconditional positive regard (Glauser & Bozarth, 2001; Rogers, 1995) and counselor qualities such as empathy (Kottler, Montgomery, & Marbley, 1998) have been described in an attempt to connect the quality of the relationship to client growth. Terms such as therapeutic alliance, therapeutic bond, and working alliance have been applied to describe the quality of the relationship between counselor and client (Peterson & Nisenholz, 1999) but are not clearly operationalized.

In the desire to operationalize curative behaviors and attitudes, various terms have been used in various counseling textbooks, but no definitive study was located that outlined what the counselor did or did not do that enhanced healing for the client. The purpose of this study was to fill that void in the counseling literature.

Theoretically Grounded Terms for Healing

The exact relationship factors that hypothetically provide for client growth have been described with various terms, usually situated in a theoretical orientation. For example, Rogers (1995) highlighted the importance of empathy,
unconditional positive regard, congruence, and matching affective expression as the core conditions of a therapeutic relationship in client-centered therapy. Similarly, Geller (2002) explored therapeutic presence, not as a technique but as the way the therapist extends self as one human being to another, and Ahern (2000) documented how therapists attempted to establish presence with clients. In terms of training, these therapeutic strategies are visible in microskills training (Ivey, D’Andrea, Ivey, & Simek-Morgan, 2007; Ivey, Ivey, & Zalaquett, 2007), in which skills are taught sequentially that culminate in transtheoretical helping behaviors.

From the gestalt tradition, contact (Perls, Hefferline, & Goodman, 1951) and supporting contact (Polster & Polster, 1974) require the therapist to be attentive and set the pace and quality of contact congruent with the client’s needs. In the psychoanalytic tradition, the holding function of the therapist (the therapist’s ability to focus on the distress of the client during therapy) is crucial (Richard-Jodoin, 1989), resting on the stability of the therapeutic environment and on the acceptance of the therapist.

From Eastern traditions have come several concepts that have been used to describe meaningful therapeutic relationship qualities. Thomson (2000) proposed that counselors practice Zazen, from the Soto School of Zen Buddhism, as a set of qualities in which the counselor becomes fully present (focused) in the client’s immediate concern. Mindfulness and willingness have been suggested by several authors (May, 1982; Murgatroyd, 2001; Nichol, 2006) as essential counselor qualities in therapeutic interaction. Specifically, Linehan (1993) described mindfulness as the core skill of dialectical behavior therapy, in which the “wise mind” (p. 214), the intuitive sense of rightness, is used to still the self in order to make better contact with the client.

Other descriptions of the curative factors in the counseling contact can be conceptualized on the basis of how emotions are addressed. Active engagement with client affect is proposed within the humanistic approach, and new therapies have been proposed that connect emotions with body sense. For example, Welwood (2001) described therapeutic unfolding as “the process of making implicit felt meaning explicit” (p. 335) through clinical presence and resonance with the client’s emotions and felt sense as a metaphor for contact within humanistic counseling. According to Hendricks (2007), validating the emotional felt sense of a client’s painful experience as well as moving deeper into the felt sense is curative, because processing emotions is crucial for focusing-oriented experiential psychotherapy.

Another phenomenon that exists in the literature about counseling and healing is witnessing. Higgins (1994) described adults who had experienced horrific childhood abuse and believed that “overcoming [abuse] hinged on fully recognizing how bad the past was and bearing extensive witness to their abuse in the attentive company of trusted loved ones and/or a respected therapist” (p. 293). Papadopoulos (1999) described his experiences with Bosnian refugees and the solace that therapeutic witnessing can bring. Likewise, Fosha (2004) suggested that “tracking and processing emotions to completion—in an emotionally-engaged patient–therapist dyad where
the individual feels safe and known—constitutes a powerful mechanism of therapeutic transformation” (p. 30). This is performed by a counselor who is empathetic, affirming, affect facilitating, affect coregulating, and emotionally engaged. Greenberg (2004) maintained that acceptance of an emotional experience is key to therapeutic transformation, and the first step in this process is awareness of emotions. In medical literature, the role of emotions has been extensively explored; for example, Cepeda et al. (2008) proposed that the emotional disclosure of patients with cancer through narrative may reduce physical pain and enhance well-being, and social psychology researchers (Harber, Einev-Cohen, & Lang, 2007) found that participants’ disclosure of painful thoughts and feelings related to a recalled betrayal counteracted the effects of emotional exhaustion.

Although various terms exist to describe the therapeutic connection, a clear description of how counselors and clients perceive the process of receiving validation and personal connection during disclosure of emotional pain is lacking (see Perls et al., 1951; Snygg, 1941). Research-based descriptions of the experience of healing interaction in the counseling milieu, from the perspective of both the counselor and the client, are nonexistent. The behaviors, attitudes, and/or statements that both counselors and clients identify as curative have not been described phenomenologically in a process perspective that can be practiced directly in clinical work and taught to counseling students. We designed the present study to address that deficit by asking nonmatched counselors and clients to describe the affective, cognitive, and behavioral aspects of their experience of therapeutic connection during sessions of emotional disclosure.

Method

Design Overview

This study was conducted as a full phenomenological study as described by Moustakas (1994). First, each of us in the research team engaged in the epoche process, in which current assumptions, perceptions, and ideas were journaled and discussed in our research group to address researcher bias and to examine how our perceptions as researchers may taint the analysis process (Moustakas, 1994). We conducted a literature review to provide context for the study into meaningful therapeutic experience, involving exploration of counseling, psychology, medicine, and nursing research. In the literature review, we examined all possible structural implications (underlying dynamics of the phenomenon under study; Moustakas, 1994), in which the focus was on related terms such as contact, rapport, connection, healing, empathy, and presence. The interview questions were derived to allow the respondents to fully explore the experience of therapeutic connection and healing, without leading the respondent to predesigned conclusions. With each interview, the data were then collected through open-ended inquiry to collect behavior, cognitions, and affect before, during, and after the experience under study (Moustakas, 1994). Each element of the design is more clearly described in the following sections.
**Researcher Bias**

The first author is a counselor educator with 20 years of clinical and counselor education experience, with research experience focused primarily in qualitative research. At the time of this study, the coauthors were all experienced counselors and doctoral students in counselor education in the first author’s program. Culturally, three members of the research team are Caucasian and two members are African American. Three members are from the local community and two are from various parts of the United States.

In terms of gender, our research team consists of four women and one man. As members of the research team, we were excited to conduct a rigorous phenomenological study as described by Moustakas (1994), and we all had courses in qualitative methodology. Biases held included the belief that counseling is a meaningful, profoundly transformative and healing experience and that this healing experience has common elements that were not adequately described in the literature. Additionally, we each had significant clinical experience and first-hand understanding of the conditions under which healing took place. These experiences were described and bracketed as much as possible to allow for true contact with the data generated through the interviews.

**Participants**

Two populations were involved in this study: counselors and clients (not matched). Counselors were defined as practicing professionals with master’s degrees or doctoral degrees in counseling and licensed to practice in the state. These participants were recruited from diverse community agencies. Representatives of the client population were recruited from our research program; we invited 1st-year counselor education students who had experienced counseling as a client. We hypothesized that, because of their professional interest in counseling, counselor education students would be less likely to experience counseling as something negative or stigmatized and thus would be willing to talk about their experiences. Furthermore, this population’s familiarity with the terminology of the profession could help them respond to the research questions and would not pose negative biases that could alter the results of the study.

A total of 14 participants were interviewed; six participants identified themselves as counselors and eight participants identified themselves as clients having received counseling at some point in their lives. The counselor respondent pool comprised five female counselors and one male counselor, all between the ages of 37 and 60 years. Three of these respondents identified as Caucasian, one identified as African American, one identified as multiracial/African American, and one identified as Japanese. The average years of counseling experience was 12.8 years; theoretical preferences included eclectic, client centered, cognitive behavior therapy, and interpersonal; two counselors claimed no theory preference or were atheoretical.
All of the client participants were women between the ages of 23 to 52 years old. Five participants identified as Caucasian, two identified as African American, and one identified as blended race Hispanic/Caucasian. The maximum time spent in counseling was 4 years.

Data Collection

After institutional review board approval was granted, potential participants were invited through flyers, e-mail announcements, and word of mouth. Volunteers contacted the first author, who assigned the interviews in consultation with the volunteer, so that participants were not interviewed by anyone on the research team with whom there were existing or potential educational or professional relationships. Each member of the research team was assigned three to four participants to interview once it was confirmed that there were no dual relationships or conflicts of interest. Informed consent was obtained from each participant for taping and future member checking. The interviews lasted from 60 to 120 minutes each. To further protect participants, we coded tapes and transcripts for anonymity; once transcribed, the tapes were destroyed. Each verbatim transcript was sent to the participant for review and approval, then to the entire team for analysis. The recruitment and interview processes continued until the data were sufficiently saturated and redundant to ensure that the full spectrum of the clinical phenomenon under study had been captured for analysis. After data analysis and synthesis, the results were sent to all participants for their feedback and suggestions; all participants (100%) approved the results as representative of their experience with only one minor edit.

Interview Questions

The interview protocol appears in the Appendix. The interview questions we developed were derived from a process of discussion, reflection, and revision to probe for the experience under study. The questions were carefully worded to avoid having the participant talk about painful experiences for which she or he sought or provided counseling; the focus was on experiences of healing after emotional disclosure. Additional feedback was sought from three expert readers who read the questions and indicated that the questions were appropriate for both populations under study.

Data Analysis

Once in the data pool, the data were examined in phenomenological reduction, in which each story is examined for each horizon; that is, each singular statement is viewed as a separate event in the phenomenon to arrive at a process view of the entire experience (Moustakas, 1994). We eliminated redundancy and minor details to reduce the experience to its essential elements. Next, we examined each lived story for the textural dimensions and
exemplars of the story, which were clustered into themes (Moustakas, 1994). These analytic processes were conducted by each member of the research team independently; we then met as a team to discuss the horizons and details deemed to be minor to arrive at consensus at this stage.

After engaged dialogue, we then synthesized the themes into a textural description—the “what” of the experience under study. In the next step of imaginative variation (Moustakas, 1994), all possible meanings for the themes were sought and phrased in meaningful ways relative to the context of the study. In this stage, we attempted to explore all possible alternative interpretations of the data to check for research bias or distortion. Consistent and inconsistent themes of the story were juxtaposed to find the invariant themes that account for the phenomenon (Moustakas, 1994). Finally, the textual and structural descriptions were then merged into a unified diagram and sent to the participants for member checking and were unanimously approved as accurately depicting the phenomenon of healing contact in counseling. These results were juxtaposed with current literature to make sense of discoveries.

**Indicators of Rigor in Qualitative Research**

Threats to validity in qualitative research involve four conditions: credibility, transferability, dependability, and confirmability (Lincoln & Guba, as cited in Marshall & Rossman, 2006). According to Kline (2008), credibility is facilitated through rigorous description of methodology; the goal of the present study is to provide in-depth description. Transferability is established through extensive triangulation. In our study, we triangulated the inquiry and the findings using literature, member checking, outside reader(s), and research team consensus. Dependability and confirmability (Kline, 2008; Marshall & Rossman, 2006) mean that the study could be confidently replicated with reasonably similar findings found through thick description of methodology and results. The subjective nature of qualitative research makes this a challenge; however, in this study, the epoche process we engaged in allowed us to explore each of our personal experiences and biases, which were then monitored during the design, data collection, and analysis phases. Additional strategies to enhance rigor in this study included cross-checking, peer debriefing, looking for exceptions to themes, using literature to look for possible alternative explanations, and recording of descriptive note taking.

**Results**

The results of this study revealed consistent events in the experiences of both clients and counselors. Findings are not reported in the order of the interview questions; the process of phenomenological analysis yields a holistic overview of the entire phenomenon. First, we present the results of the client participants, followed by those of the counselor participants, and finally a synthesis of both.
Client Participants’ Descriptions

As depicted in Figure 1, what is helpful must be bracketed by what is not helpful. “Not helpful” experiences can be described by three types of disrespect: disrespect of client (being “cut off,” “laughed at,” and “yelled at”), disrespect of culture (being “labeled” and “pathologized”), and disrespect of process (the counselor asked no questions, provided no insight, demonstrated no interest, and gave advice). As a result, clients reported feeling “stupid,” “hopeless,” “more alone,” “violated,” “misunderstood,” and “unsafe.” As one participant stated, “You didn’t feel the caring or support at all. . . . You felt insignificant and stupid and more alone . . . even worse than you did before.” Another participant recalled her counselor’s reaction to a relapse: “It was a verbal slap in the face. . . . She seemed angry and I was confused about what just happened. I remember being so grateful that our time was up, ‘cause I just wanted to get out of there.”

In contrast, when clients described their most meaningful counseling experiences, they consistently described what the counselor did and how the counselor was. They described the actions of the counselor as “present,” “quiet listening,” and “drawing out and accepting feelings”; they said that the counselor “saw my world,” “accepted me,” and “showed it without saying a word.” One participant said, “We had the same set of glasses on.” Another said, “[The counselor was] pulling something from my brain that I

![Figure 1](image-url)

**Client Participation Themes**

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was thinking but didn’t know how to say.” Physically, the counselor “made eye contact,” “gave me their full attention,” and served as the “beacon in the lighthouse” as a source of hope. The counselor was uniformly described as “calm,” “patient,” “genuine,” “empathic,” “sincere,” “warm,” and “positive,” with “a good sense of humor.” One participant described her counselor this way: “She’s so sincere in every word that comes out of her mouth [you tell] that she really means it.”

Client participants described their affective experience of that meaningful connection as “affirmed,” “validated,” “understood,” “heard,” “cared about,” “empowered,” “encouraged,” and “hopeful.” As stated by one respondent, “Relief that you are not the only person in the world that thinks or feels this way. . . . Thank you. Grateful. Grateful.” After the session in which clients experienced connection with the counselor, they felt “relieved,” “free,” “warm bath/warm fuzzy,” “crying with relief,” “weight off,” “head up,” and “profoundly grateful.” One respondent stated, “It was the full-body all-over, just kind of like the tension was eased, like muscles that were tense that I didn’t realize are now relaxed” and “You leave your session and you’re almost like bouncing out of the office because that just feels so good.” Another respondent echoed her words with “Then when . . . you know that someone understands you it’s kind of like this full-body exhale and like tension just eases and oh, the load off your shoulders is so nice, it’s like warm-bath relaxation.” It was after this point that client respondents indicated that they could then engage in the cognitive work of counseling, in which the counselor “questioned,” “challenged,” and gave “honest feedback,” a “reality check,” “objectivity,” and “reframe.” As stated by one respondent, “I actually felt better after the fact [intense emotion] and the more times that I cried about the situation the better off I was. . . . Then she challenged some of my thoughts and even some of my feelings.”

Counselor Participants’ Descriptions

As can be seen in Figure 2, the counselor participants’ experiences were similar to those of the client participants. When describing sessions in which connection did not occur, counselors described experiences that were similar to those described by client participants. They told of sessions in which they engaged in “telling,” “teaching,” “problem solving,” and “advice giving.” One respondent said, “What was not helpful? The advice or problem-solving stuff, not helpful.” Two counselors touched on the role of culture and said that connection was difficult if they shared too much about their experiences and if they could not identify with the client’s culture. Connection was enhanced if they could identify with the client’s issues by sharing, for example, “I too have struggled.” The role of cognition was mentioned by three of the six counselors, who indicated that focusing too much on “book learning” or theory by intellectualizing the client’s issue blocked their ability to establish a meaningful therapeutic
connection. One counselor said that in preparing for a session, “I try to go ‘in’ as far as possible. I need to be rid of all theory. I let my spirit use my head, instead of my head using my spirit.”

The counselor participants described the connection process in consistent terms. In this process, the client’s pain was manifested in affect (“shame,” “guilt,” “detachment,” “self-neglect,” and “fear”) and in body (“could see it in their body language,” “no eye contact,” “as if she was carrying a heavy burden”). According to one counselor, “They just needed to be connected . . . both of them were so detached from anyone.” Another said, “Crying . . . Shame because they have a difficult time making eye contact. Guilt because they struggle to make eye contact and then their voices become lower as if they’re telling a secret.” In response to the pain they perceived in the client, the counselor participants felt a “call to action”; “call to helping”; or a pull in the “gut,” “core,” “stomach,” “back,” “chest,” and “heart.” One counselor stated,

I give my heart to the other person’s heart . . . So the moment I noticed the connection is that my heart meets their heart then there is some merger or connection there. . . . At first I have to feel that their heart is opened up. . . . I felt that I could hear the clicking that they opened the door. And then after that how much of my heart will they take?
What was described next was consistent among the counselors: Their response to the perceived pain included attending to the pain, “emotional knowing,” “open[ing] myself up,” saying “I feel you.” They became “still” to better “listen,” “witness,” “ground myself,” and “offer silence.” One counselor said, “Simply listening nonjudgmentally to what the client is telling me, and sitting and holding the pain for them.” Another described her experience of the connection as follows:

For me, that means that I can see myself in that other person and I try to open up myself to that other person so that they can see themselves in me. Once you are able to look at another person and see yourself, see your own experiences and see you own life, that is what a connection means to me. When you can actually see that person’s pain.

The counselors paced the session by “walking with, not in front of the client” and engaged in “silent waiting for the client.” This merged with what they knew of themselves that enabled them to help others. They spoke of their own spirituality and “inner healing”; feeling “connection to all”; and having “faith,” “hope,” “authenticity,” and being a “natural helper.” One counselor spoke about how the connection in counseling brought connection to the client’s life:

I have a lot of clients that end up . . . feeling connected even to strangers, to people they don’t know, to animals, to things that our culture doesn’t really embrace as something to be connected to. . . . When a client says to me not only am I connected with myself, but I’m connected to things outside of me because I see those things as a powerful part of me, those are the best counseling sessions.

After the connection experience, the counselor participants felt “more energy,” “affirmed,” “more present,” and more comfortable that what they were doing was helpful. They reported that clients expressed relief through statements such as “a burden has been lifted” and “it’s off my back.” One counselor said, “I can sometimes feel a palpable sense of relief in the room emanating off them [the client].” Clients were reported to make eye contact, take ownership over their issues, and share more “hard things.” As one counselor stated, “They keep coming back and they tell me other hard things. . . . I think it’s when they start taking some of the ownership that is the best feeling for me, because to me that’s them making progress.” Often, gratitude was directly expressed. At this point, cognitive work (if a part of the counselor’s orientation) was engaged. One counselor said, “I give some feedback like that, and sometimes I can get them to see things differently, but without giving advice, but try to help them brainstorm different possibilities.”

**Synthesis**

As we identified consistent essential elements of the phenomenon of therapeutic connection as described in the two previous sections for client and counselor participants, the invariant textural and structural
dimensions became evident (Moustakas, 1994). Lack of empathy, lack of respect, intellectualizing, and lack of interpersonal skills prevented the therapeutic connection from occurring. All of the respondents spoke of the speed with which the lack of connection was apparent to them, indicating that the potential for connection was assessed from the first moments of counseling.

As the therapeutic relationship developed, counselor actions and attributes created the environment in which clients could self-disclose. When client pain was expressed either verbally or nonverbally, counselors disclosed that they felt some calling to respond, reporting some discomfort as the cue to attend to the client’s affect. The counselor’s skills and personal attributes served to deepen the potential for connection and engender trust, instill hope, and share appropriate background information.

Professional skills that prompted connection included the use of silence, emotional attending, remaining grounded, witnessing, empathy, and pacing. The counselor attributes of faith, hope, authenticity, warmth, and patience served to affirm, empower, and encourage the client. Growth was experienced by both the counselors and the clients, in that counselors experienced a renewal of energy and purpose, and the clients experienced concurrent expansion of a more holistic sense of self and contraction of pain through gaining perspective and affective relief.

Finally, to move forward, the counselor and the client continued to process and contextualize the client’s pain. When the connection was effective, the client was willing to take ownership and share more “hard stuff” with the counselor. Counselor activities shifted to cognitive interventions as needed to facilitate continual client growth as congruent with the counselor’s theoretical orientation.

Discussion

This study shows significant potential for understanding therapeutic connections with clients. However, findings must be contextualized with several limitations that constitute threats to the integrity of the results. First, this study, although achieving data saturation, consists of the phenomenological experiences of 14 people. Because of the nature of qualitative inquiry, variable interpretations of the data will exist. Furthermore, the study reflects a predominantly female respondent pool. To balance these concerns, we took care to recruit diverse participants with variable theoretical orientations, to bracket preconceptions, to fully engage the diverse members of our research team in active discussion and debate, and to suspend conclusions until all participants could comment on the accuracy of the figures. Although counselor participants of this study came from various theoretical orientations, it would still be of value to conduct replication studies with practitioners of discrete theoretical schools to capture and describe experiences of meaningful connections within various therapeutic traditions.
Viewing these findings in the context of the literature does provide support for the viability of the results. Although the focus of this study was on “the most meaningful counseling experience” of clients and counselors, there is support for the importance of counselor qualities such as hope, warmth, authenticity, and acceptance as found in the client-centered and humanist traditions (Friedman, 2001; Kottler & Hazler, 2001; Rogers, 1995). The description of faith, hope, and spirituality mentioned by the client participants is also consistent with humanism (Elkins, 2001). Other counselor qualities such as presence (Ahern, 2000; Geller, 2002), supporting contact (Polster & Polster, 1974), mindfulness (Murgatroyd, 2001; Nichol, 2006), the holding environment (Richard-Jodoin, 1989), and willingness (May, 1982) are interpretable from the findings in which contact with client pain is engaged with courage. Specifically, the counselor activity of witnessing client pain without fear supports the findings of Higgins (1994), Papadopoulos (1999), and Cepeda et al. (2008) and the positions of Fosha (2004) and Greenberg (2004), who posited that processing emotional pain is vital for client growth.

Implications for Practice

From the present study, it is evident how important it is for counselors to foster therapeutic connections. Although rapport building, presence, and mindfulness are all highly desirable and needed components of the therapeutic experience, the intentional creation of deep therapeutic connection allows greater processing and healing to take place. The client feels connected to the counselor, and together they can move forward to active interventions not possible prior to the connection. As the clients and counselors both reported, the working relationship significantly changed for the better the moment this connection took place. Counselors need to recognize the potential in this and gain greater self-awareness regarding the client’s presenting concerns as well as feelings about the client. Understanding self and situation is crucial to allow a deep connection and relationship.

Furthermore, the deep connection created a safe place for processing pain, which cleared the emotional blockage to make way for cognitive work. This would have important implications for cognitive-oriented counselors, who may view these findings as germane only to affect-oriented practitioners. It may be incumbent on all counselors to reflect on the dynamic interplay between affect and cognition (Goleman, 1995) in order to foster deep therapeutic connection as needed to diffuse client distress before attempting cognitive interventions.

Conclusion

Is the therapeutic relationship both necessary and sufficient, as Rogers (1995) claimed? On the basis of the respondents’ experiences, the relationship is necessary and sufficient for the emotional catharsis that preceded cognitive
processing. Contrary to those therapeutic traditions that claim that a working relationship is all that is needed (e.g., rational emotive behavior therapy [Ellis, 1973] and solution-focused behavior therapy [Sklare, 1997]), it seems that counselors would be more likely to provide meaningful and helpful counseling services if they first facilitated the client’s emotional expression as appropriate. For counselors who prefer a more affect-oriented therapeutic approach, the insights from this study could reaffirm that therapeutic efficacy is not always measured in weeks toward a goal but rather in the quality of the connection between the counselor and the client.

References


APPENDIX
Interview Questions

Counselor Questions
1. Demographics
   a. Age, gender, time as a professional counselor, ethnicity
   b. Theoretical orientation (humanist, behaviorist, etc.)
2. We are studying what counselors do when a client talks about a very painful emotional event.
   a. What is your internal reaction when a client tells you about a painful or sad event?
   b. To what extent do you show the client what you are feeling or thinking when a client shares something painful?
3. Describe a time during a counseling session in which you felt as if you were seeing the client's painful experience firsthand, when you felt a deep or profound understanding of the client during a counseling session.
   a. What do you call that sense of deep understanding?
   b. How did that deep sense of understanding feel to you? Describe where in your body you experienced it.
   c. Without using any counseling jargon, describe what you say and do when a client is expressing painful memories or painful thoughts.
   d. What did you do that was powerful or profound to you in the moment?
   e. How did you know if it is helpful to the client? What does the client do or say that helps you know that what you have done is meaningful for the client?
4. Describe the best counseling session you have ever had with a client. What made it the best?
5. Describe an experience when you noticed the client sensing your support and presence. Describe an experience when you offered yourself to the client and the client didn’t sense your support and presence.
6. Recall a time in your personal life that you told someone about a source of pain in your life.
   a. What did the listener say or do?
   b. What was helpful to you in that moment? What was not helpful in that moment?
   c. What do you wish the listener had said or done differently to be more helpful to you at that time?
7. What about you as a person enables you to support/validate clients? How do you know this?

Client Questions
1. Demographics
   a. Age, gender, ethnicity
   b. How long have you been or how long were you in counseling?
   c. Would you say that, overall, counseling has been helpful to you?
2. Describe the most meaningful moment in your counseling experience.
3. If you have felt an intense sense of sadness and pain during a counseling session:
   a. What was it like for you?
   b. How did your counselor handle it?
   c. What was most helpful in that session?
4. What would be most helpful to you during a counseling session when you are feeling an intense sadness during counseling?
5. Tell me about a time when you felt that you were really understood during a counseling session, that the counselor really “got it.”
   a. What would you call it?
   b. What did it look like? How do you know if someone really gets what you’re saying or what you’re feeling?
   c. How did it feel? Describe what happens inside of you when you feel true understanding and support from your counselor. Describe where in your body you experience that sensation of understanding and support.
   d. Tell me about a time when your counselor tried to “get it” but didn’t.