Psychotherapy
2011, Vol. 48, No. 1, 65–71

0033-3204/11/$12.00 DOI: 10.1037/a0022064

Congruence/Genuineness

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Congruence or genuineness is a relational quality that has been highly prized throughout the history of psychotherapy, but of diminished research interest in recent years. In this article, we define and provide examples of this attribute of the therapy relationship and present an original meta-analytic review of the empirical literature showing its relation to improvement. Analysis of 16 studies (k), representing 863 patients (N), resulted in a weighted aggregate ES (r) of .24 (p = .003; 95% CI = .12 to .36). Moderators of the association between congruence and treatment outcome are examined, and limitations of the extant research are discussed as well. In closing, we advance several therapist practices that are likely to foster congruence and thus improve psychotherapy outcomes.

Keywords: congruence, genuineness, therapy relationship, psychotherapy outcomes, meta-analysis

Throughout the history of psychotherapy, congruence or genuineness has been highly valued and sought as a relational quality of the therapist. However, congruence has received diminished research interest in recent years. In this article, we return to this vital element of the therapy relationship by reviewing its definition, measurement, and manifestation. We summarize an original meta-analysis on the association between congruence and psychotherapy outcome and conclude with therapist practices predicated on this body of research.

Definitions and Measures

In 1957, Carl Rogers characterized the necessary and sufficient conditions of therapeutic change as the client being in a "state of incongruence," the client and therapist in "psychological contact," and the therapist as "congruent or integrated in the relationship" and experiencing "positive regard for the client" and "an empathic understanding of the client's internal frame of reference" (p. 96). This characterization underscores two facets of congruence. The first refers to the therapist's personal integration in the relationship, that "he is freely and deeply himself, with his experience accurately represented by his awareness of himself" (Rogers, 1957, p. 97). These days we might say that the therapist is mindfully genuine in the therapy relationship, underscoring present personal awareness, as well as genuineness or authenticity.

The second facet of congruence refers to the psychotherapist's capacity to communicate his or her experience with the client to the client. This requires careful reflection and considered judgment on the part of the therapist. While the aim is not for the therapist to indulge in indiscriminant self-disclosure or ventilation of feelings, he or she must not deceive the client about his or her feelings, especially if they stand in the way of therapeutic progress. Neither empathy nor regard can be conveyed unless the therapist is perceived as genuine.

The concept of congruence can at times seem abstract and elusive. Consider how this relational quality might appear in everyday interactions with people in your world. Insurance agent Jones is quite formal and proper while appearing to be playing a prescribed role. Mr./Ms Jones interacts in a relationally incongruent manner. Coffee barista Brian warmly greets you by your first name, attentively asks after your family, and openly shares his opinion about a movie he recently took in. Brian engages you, makes contact, and sincerely expresses himself in the brief time it takes to pour and pay for a cup of coffee. Brian interacts in a relationally congruent fashion.

In psychotherapy, this means that the therapist is openly "being the feelings and attitudes which at the moment are flowing within him" (Rogers, Gendlin, Kiesler, & Truax, 1967, p. 100) and not hiding behind a professional role or holding back feelings that are obvious in the encounter. Congruence thus involves mindful self-awareness and self-acceptance on the part of the therapist, as well as a willingness to engage and tactfully share perceptions.

Although most fully developed in the client-centered tradition, therapist congruence is highly valued in many theoretical orientations. The notion of the *therapist real relationship* (Gelso & Carter, 1985; Gelso & Hayes, 1998), for example, is conceptually similar to congruence/genuineness and is consistent with ideas initially offered by psychoanalysts (e.g., Greenson, 1967). The real relationship is seen as primarily undistorted by transferential material and comprised to two defining features: genuineness and realistic perceptions. Genuineness is viewed as "the ability to and willingness to be what one truly is in the relationship . . ." (Gelso & Carter, 1994, p. 297). Genuineness is also related to other terms, such as authenticity, openness, honesty, and nonphoniness (Gelso & Hayes, 1998).

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This article is adapted, by special permission of Oxford University Press, from a chap. of the same title by the same authors in J. C. Norcross (Ed.), (2011). *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press. The book project was co-sponsored by the APA Division of Psychotherapy.

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In the current literature, genuineness is frequently considered the most important of the three Rogerian facilitative conditions. Moreover, Lietaer (1993) has offered a conceptualization of genuineness with both an internal and external facet. The internal facet ". . . refers to therapists' own internal experiencing with their clients . . . To the extent that therapists are able to be in touch with their own experience they may be termed congruent" (Watson, Greenberg, & Lietaer, 1998, p. 9). The external facet ". . . refers to the therapists' ability to reveal their experience to their clients. This is termed transparency . . . it is not necessary to share every aspect of their experience but only those that they feel would be facilitative of their clients' work. Transparency is always used in an empathic climate" (Watson et al., 1998, p. 9).

There has also been some broadening of the definitions of congruence to include *therapeutic presence* (Geller & Greenberg, 2002). In an interview, Carl Rogers said, "Over time, I think I have become more aware of the fact that in therapy I do use myself. I recognized that when I am intensely focused on a client, just my presence seems to be healing" (Baldwin, 1987, p. 29). In addition to the three basic conditions "perhaps it is something around the edges of those conditions that is really the most important element of therapy—when myself is very clearly, obviously present (p. 30). Presence implies a dual level of mindful awareness whereby the therapist balances contact with his or her own experience and contact with the client's experience to maintaining a "place of internal and external connection" (Geller & Greenberg, 2002, p. 83). "The communicative aspects of congruence involve the ability to translate intrapersonal experience into certain types of interpersonal responses" (Greenberg & Watson, 2005, p. 127). A congruent interactional response involves a therapist's conveyance of "attitudes or intentions of being helpful, understanding, valuing, respecting and being nonintrusive or nondominant" (p. 129). Thus, congruence is more than avoiding formality on the one hand, or phoniness on the other; it entails the therapist's attentive recognition and nonjudgmental acceptance of feelings, perceptions, and thoughts, both positive and negative.

Barrett-Lennard (1959) developed what has become the most recognized and validated therapist- or patient self-report assessment of the core conditions (including congruence): the Barrett-Lennard Relationship Inventory (BLRI; see Barrett-Lennard, 1962). Parallel forms of the BLRI ask the therapist to describe his or her feelings toward the client while in session (e.g., " I am willing to tell him my own thoughts and feelings") or the patient to describe his or her experience of the therapist (e.g., "He is willing to tell me his own thoughts and feelings"). The original 92-item version of the BLRI included five scales: level of regard, empathic understanding, unconditionality, genuineness, and willingness to be known. This last scale was merged into the genuineness/congruence scale in the 64-item 1964 revision (Barrett-Lennard, 1978).

Truax developed a version of the BLRI entitled the Truax Relationship Questionnaire (TRQ; see Truax & Carkuff, 1967) as a self-report assessment of the core conditions. In addition, Carkhuff (1969) specifically developed a scale of genuineness derived from the Truax scale for broad application to interpersonal interactions. The Carkhuff scale differs from Truax's version in that it includes more of an emphasis on negative reactions resulting from moderate to low levels of genuineness. More recently, patient and therapist versions of a Real Relationship Inventory have been published (Gelso et al., 2005). Items for the Real Relationship Inventory include 12 for "Realism" and 12 for "Genuineness."

The reliability of the two most frequently used measures of the core conditions—the BLRI and the Truax scale—has generally been adequate. Most internal and test–retest reliability coefficients for the BLRI range between .75 and .95 with the majority exceeding .80 (Barrett-Lennard, 1998). Internal reliabilities for the Real Relationship Inventory were.79 for Realism and .83 for Genuineness (Gelso et al., 2005).

Clinical Examples

Therapist Perspectives

The following excerpt is an example of Carl Rogers' description of how his clinical work led him to refine the experiential component of client-centered therapy (Rogers et al., 1967). In this example Rogers explains how his personal awareness and communication of feelings about the difficulty ending a session provides a "vehicle for therapeutic responding" (p. 389):

> Some of my feelings about him (the patient) in the situation are a good source of responses, if I tell them in a personal, detailed way . . . . . One whole set of feelings I have for others in situations comes at first as discomfort. As I look to see why I am uncomfortable I find content relevant to the person I am with, to what we just did or said. Often it is quite personal. I was stupid, rude, hurrying, embarrassed, avoidant, on the spot: I wished I didn't have to go since he wants me to stay. I wish I hadn't hurried him out of the store in front of all those people. Or, "I guess you're mad at me because I'm leaving. I don't feel very good about it either. It just never feels right to me to go away and leave you in here [hospital ward]. I have to go, or else I'll be late for everything I have to do all day today, and I'll feel lousy about that." Silence. "In a way, I'm glad you don't want me to go. I wouldn't like it at all if you didn't care one way or the other." (p. 390)

In reflecting on these moments, Rogers explains that:

> These . . . have in common that I express feelings of mine which are at first troublesome or difficult, the sort I would at first tend to ignore in myself. It requires a kind of *doubling back*. When I first notice it, I have *already* ignored, avoided, or belied my feelings - only now do I notice what it was or is. I must double back to express it. At first, this seems a sheer impossibility! How can I express this all-tied-up, troublesome, puzzling feeling? Never! But a moment later I see that it is only another perfectly human way to feel, and in fact includes much concern for the patient, and empathic sensitivity to him. It is him I feel unhappy about - or what I just did to him.
>
> A very warm and open kind of interaction is created in telling my feelings this way. I am not greatly superior, wiser, or better than the other people in the patient's life. I have as many weaknesses, needs, and stupidities. But the other people in his life rarely extend him this kind of response (pp. 390).

Patient Perspectives

How is congruence offered by the therapist perceived by the patient? The patient's experience of the highly self-congruent therapist is that the therapist is fully at ease within the relationship and is openly him or herself. Being attuned to his or her experience in the moment, the therapist is open to honestly sharing this experience with the patient and does not avoid sharing uncomfort-

able feelings and impressions that are important to treatment. Because of this personal attunement and genuineness, the therapist's words accurately capture his or her momentary experience.

Observer Perspectives

A third perspective on genuineness is provided by the observer, such as gleaned from transcripts. The following example comes from the transcripts of Carl Rogers's filmed demonstration session with the client "Gloria" (Shostrum, 1966) where he clearly expresses his feeling of closeness to Gloria:

> Gloria: That is why I like substitutes. Like I like talking to you and I like men that I can respect. Doctors, and I keep sort of underneath feeling like we are real close, you know, sort of like a substitute father.
>
> Rogers: I don't feel that is pretending.
>
> Gloria: Well, you are not really my father.
>
> Rogers: No. I meant about the real close business.
>
> Gloria: Well, see, I sort of feel that's pretending too because I can't expect you to feel very close to me. You don't know me that well.
>
> Rogers: All I can know Is what I am feeling and that is I feel close to you in this moment.

Meta-Analytic Review Method

The empirical evidence for the relation between therapist congruence or genuineness and client outcome has been previously reviewed by at least 10 sets of researchers (in chronological order: Meltzoff & Kornreich, 1970; Truax & Mitchell, 1971; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Kiesler, 1973; Lambert, DeJulio, & Stein, 1978; Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978; Orlinsky & Howard, 1978, 1986; Watson, 1984: Orlinsky, Grawe, & Parks, 1994). The consensus of these reviews is that empirical support for the contribution of congruence to client outcome is mixed, but leaning toward a positive endorsement.

Search Strategy

In order to identify studies to include in the present review, we narrowed our focus to published studies (in English) and dissertation research on individual or group therapy with adults or adolescents (thereby excluding studies of psychotherapy with children and unpublished research reports). As such, we conducted PsycINFO and MEDLINE searches using the keywords "congruence," "genuineness," and "psychotherapy." In our previous review (Klein et al., 2002), we identified 20 articles meeting the above criteria. For the present review, we identified five more potential articles.

Inclusion Criteria

In order to be included in the meta-analysis a study had to include quantitative information adequate to calculate an effect size (e.g., a correlation coefficient). This procedure resulted in 14 articles reporting 16 studies that were included in our meta-analysis (see Table 1). Eleven of the 25 identified articles were excluded due to insufficient information. Table 1 lists studies included in our meta-analytic review and provides summary information with respect to (a) aggregate effect size (for those studies that included multiple reports of congruence-outcome relations); (b) type and perspective of congruence measure; and (c) type and perspective of outcome measure. Kolden, Klein, Wang, and Austin (in press) provides a more comprehensive coverage of the congruence construct, meta-analytic procedures used, and references.

Table 1
Studies Included in Meta-Analytic Review

Reference	Effect size (*r*)	*N*	CM	C*p*	OM	O*p*
Athay (1973)	.24	150	2	1	4	1,2
Buckley et al. (1981)	.06	71	3	1	1,2,5	1
Fretz (1966)	.25	17	1	1,2	4	1,2
Fuertes et al. (2007)	.34	59	3	1,2	4	1,2
Garfield & Bergin (1971)	−.26	38	3	3	1,4,5	1,2,3
Hansen et al. (1968)	.69	70	1,3	1,3	5	1
Jones & Zoppel (1982)	−.02	99	3	1	1,3,4	1
Marmarosh et al. (2009)	.41	31	3	1,2	1	1
Melnick & Pierce (1971)	.42	18	3	3	5	1
Ritter et al. (2002)	.21	37	1	1	1,2,5	1
Rothman (2007)	.50	44	1	1	2,4	2
Staples et al. (1976)	.16	17	3	3	4	3
Truax (1966)	.38	63	1,3	1,3	4	1
Truax (1971)	−.02	34	2	1	1,5	1
Truax (1971)	.28	72	2	1	1,5	1
Truax (1971)	.11	43	2	1	5	1

Note. *N* = total number of participants per study; CM = congruence measure (1 = Barrett-Lennard Relationship Inventory [BLRI], 2 = Truax Relationship Questionnaire [TRQ], 3 = other scales/checklists); C*p* = congruence perspectives (1 = Client, 2 = Therapist, 3 = Observer); OM = outcome measure (1 = symptoms [e.g., Anxiety, SCL-90-R], 2 = functioning [e.g., GAFS, adaptive skills/coping], 3 = well-being [e.g., overall success], 4 = global [a measure focusing on general change without any particular dimension], 5 = other [e.g., MMPI, satisfaction, self-concept, goal attainment, personality, Q-sort, self-efficacy, self-esteem]); O*p* = outcome perspectives (1 = Client, 2 = Therapist, 3 = Observer).

Methodological Decisions

The effect size (ES) we used was *r,* the correlation coefficient for the relation between congruence and outcome. Each study was reviewed and coded by two raters (coauthors Wang and Austin). Discrepancies in original coding were negotiated in a consensus discussion involving the first author. If *r* was not available or nonsignificant (and not reported), we adopted the strategy of entering zero as the effect size (Lipsey & Wilson, 2001).

For studies reporting multiple correlations and using multiple measures, we aggregated within each study by accounting for the dependencies of measures. The within study aggregation used the correlation matrix among measures if reported. Otherwise, we assumed that the correlation among measures was .50 when the same method was used (e.g., self-report congruence and self-report outcome) and a correlation of .25 when different methods were used (e.g., self-report vs. observation; Gleser & Olkin, 1994). The overall correlation was estimated by aggregating the correlation of each study using a weighted average where the weights were the inverse of variance of the estimates of the study level correlations (Hedges & Olkin, 1985). Inverse of the variance is dependent on the sample size so that studies with larger sample sizes were weighted more heavily than studies with smaller sample sizes.

A test of homogeneity, using Hedges and Olkin's (1985) *Q* statistic, was conducted to determine if the effect sizes among studies were homogeneous. We adopted a random effects model for determining overall effect size (ES) since the studies we identified were quite heterogeneous ($Q = 35.32$, $p < .01$), thus violating the assumptions required for fixed effects ES modeling (e.g., homogeneity of sample, variation in study ES due only to sampling error; Hedges & Vevea, 1998). Moreover, random effects modeling allows for greater generalizability. In addition, if the analysis showed between-study heterogeneity, weighted univariate regression or weighted between group tests were used to examine moderator variables.

Results

Estimates of effect sizes (ESs) in the 16 studies (k) representing 863 participants (*N*) ranged from −.26 to .69. The weighted aggregate ES for congruence with psychotherapy outcome was .24 ($p = .003$; 95% CI = .12 to .36). The overall ES of .24 for congruence is considered a small to medium effect (Cohen, 1988) and accounts for 6% of the variance in treatment outcome. This provides evidence for congruence as a noteworthy facet of the psychotherapy relationship. Yet, this finding must be cautiously interpreted, as publication bias favors significant results; thus, this ES may be an overestimation of the true congruence-outcome relation in psychotherapy. At the same time, this ES could also be an underestimation as we used the conservative assumption of treating unreported, nonsignificant results as zero.

Moderators

The finding of heterogeneity of ESs among studies led us to examine the extent to which potential moderators accounted for the variability in magnitude of the congruence-outcome association across the studies. As noted above, weighted univariate regression or weighted between group tests were used to examine moderator variables. Specifically, we examined potential moderator influences in the form of measurement-related variables, therapist variables, client variables, and treatment variables.

Measurement Variables

We found that client-rated outcome ($r = .29$) produced a significantly higher ES than therapist-rated outcome ($r = .07$) ($QB = 8.05$, $p < .05$). This may be due to the fact that both congruence and outcome were more often assessed from the client perspective and is consistent with the observation that relations within perspective (client-rated process and client-rated outcome) are often more robust (Hill & Lambert, 2004). Of course, it is also important to consider that this may be simply an artifact of method variance. At the same time, these constructs are highly phenomenological in nature, and relations like this are likely to be best captured by within perspective self-report.

Therapist Variables

The mean number of years of therapist clinical experience across five studies was 7.2 years (clinical experience ranged from 0 years for trainees to 13.6 years, with a median of 5.6 years). Results from a weighted univariate regression analysis indicated a positive relation between therapist clinical experience and the congruence-outcome ES ($B = .05$, $p < .01$).

Client Variables

Perhaps because most of the studies included in this meta-analytic review were published prior to 1990, client descriptive information was seldom reported; consequently our results are limited. Educational attainment for clients was 11.6 years on average across the studies included in this meta-analysis. This is somewhat low (when compared to typical adult outpatient psychotherapy samples) due to the inclusion of 3 studies involving adolescent clients. The mean years of education was 9.2 for the adolescent studies and 14.5 for the adult studies, indicating that most of the adults had completed at least some college, which is consistent with the adult outpatient therapy research literature (cf. Vessey & Howard, 1993). According to the weighted univariate regression analysis, client education moderated the magnitude of the congruence-outcome relation. As education decreased, the congruence-outcome relation increased ($B = -.09$, $p < .001$). Clients with less education were more likely to demonstrate a greater congruence-outcome relation; in other words, therapist congruence is more important for outcome with less educated clients.

Client age as a continuous variable was not a significant moderator, but we dichotomized age as adolescent versus adult in order to clarify the previous finding regarding education. Adolescent versus adult moderated the congruence outcome relation. Studies examining the congruence-outcome relation in adolescents ($r = .42$) attained a significantly higher ES that those using adult clients ($r = .19$) ($Q_B = 7.15$, $p < .01$). Thus, it appears that therapist congruence may be more important for outcome in adolescent clients.

Treatment Variables

For theoretical orientation, studies in a mixed category (described as eclectic, client-centered, or interpersonal; $r = .36$)

attained significantly higher ESs than those characterized as psychodynamic ($r = .04$; $QB = 8.76$, $p < .01$). One could speculate that congruence is more important for outcome in a more present-oriented, problem-focused therapy in contrast to psychodynamic approaches.

The ESs among therapeutic settings also showed significant differences. School counseling centers ($r = .43$), inpatient settings ($r = .27$), and mixed settings ($r = .23$) had a significantly higher ES than outpatient mental health settings ($r = -.02$; $QB = 16.47$, $p < .01$). School counseling centers also had a significantly higher ES than mixed settings. This finding is difficult to interpret without resorting to conjecture.

Finally, we examined the effect of psychotherapy format (group vs. individual) on the congruence-outcome association. Group therapy studies ($r = .36$) obtained a higher ES than those examining individual therapy ($r = .18$; $QB = 5.55$, $p < .05$). Congruence may be more important for outcome in group therapy. However, this finding might have more to do with the characteristics of the clients involved than the format per se given that adolescents (see findings for age and education) and inpatients were highly represented in the group therapy condition.

Patient Contribution

Congruence/genuineness is both *intrapersonal* and *interpersonal*. It can be seen as a *personal characteristic* (intrapersonal) of the psychotherapist as well as a *mutual, experiential quality* of the relationship (interpersonal).

All of us have different needs, preferences, and expectations for relationships; clients bring these to the therapy relationship. One can assume that the desire for congruence varies across clients as well. Some would like a more congruent therapist, some less. Cultural background, for example, has an important influence on client predilection for congruence. Members of other cultures often approach psychotherapy in fundamentally different ways than their westernized counterparts (Patterson, 1996). To illustrate, the value in Western psychotherapy for autonomy and independence may not hold true for interdependently oriented clients from eastern cultures (Tseng, 1999). Personal autonomy and self-differentiation is often discouraged in such clients; instead they may desire a more structured relationship in which the therapist takes on a more formal, directive, and authoritative (i.e., less congruent) role (Sue & Sue, 2003). Congruence match between client and therapist (Zane, Hall, Sue, Young, & Nunez, 2004) may therefore be of great consequence for the therapy relationship.

A client who has greater needs and expectations for congruence is likely to find comfort and satisfaction (an emotional bond) with a highly congruent therapist. These clients require a therapist to: be comfortable and at ease; be "real and genuine"; say tactfully what s/he is feeling and thinking; naturally express honest/ authentic impressions; not avoid, hide, hold back, or fail to be direct when the "elephant in the room" requires confrontation. Clients in a congruent therapy relationship learn that they are capable and worthy of time and attention, that they matter as a person with strengths and weaknesses, regrets as well as hopes and dreams for the future. Therapist commitment to truthfulness promotes client acceptance of the problems they face as well as efforts to change.

Limitations of the Research

Any inferences arising from our meta-analysis of congruence-outcome relations must consider the methodological limitations of the studies included as well as the meta-analytic methods used. Previous researchers have noted limitations of studies included in our meta-analysis: studies not limited to clients in need of change; low levels or restricted ranges of congruence; different rating perspectives; use of ratings from audiotapes that do not allow nonverbal behaviors to be considered; varying qualifications and/or training of raters; inadequate and variable sampling methods; and small sample sizes (see Parloff et al., 1978; Patterson, 1984; Lambert et al., 1978; Watson, 1984). It is also important to note the paucity of recent studies examining the congruence-outcome association and the lack of any randomized controlled trials investigating the causal impact of congruence. Caution is therefore warranted.

Moreover, it is important not to overgeneralize. Positive findings for congruence/genuineness have appeared primarily in studies investigating client-centered, eclectic, and interpersonal therapies. As such, researcher bias (an allegiance effect) is one possible explanation for our results. Additionally, congruence/genuineness may not be as potent a change process in all types of therapy nor with all kinds of clients. Congruence may only be important for client change in the context of the other facilitative conditions; for example, as a precondition for the impact of either empathy or positive regard.

Qualitative and quantitative reviews must grapple with what is referred to as the "file-drawer problem" or bias associated with the disproportionate inclusion of published studies along with the exclusion of unpublished studies (as well as those missed or excluded) in researchers' file drawers. Generally speaking the larger the number of studies included in a meta-analysis the greater the confidence in the stability of the results. While the present review includes 16 studies, we used aggregation procedures giving greater weight to larger sample studies (with smaller variances), thus reducing, or at the very least mitigating, the extent of the file drawer problem in our review. We also conducted a Fail Safe *N* analysis (FSN; Rosenthal, 1979) as well as an Adjusted Fail Safe *N* analysis (AFSN; Iyengar & Greenhouse, 1988) to estimate the number of unpublished, missed, or excluded studies with an effect size of 0 that would have to exist in order to invalidate or overturn our results. The FSN value for our analyses is 1265 and the AFSN value is 281, both well beyond the criterion suggested by Rosenthal (1979) of 90 unavailable studies with an effect size of 0 (Rosenthal formula: $5K + 10$, $K = 16$).

While meta-analytic techniques hold great utility in quantitatively integrating and summarizing results across studies, careful consideration is also reasonable. Additional concerns for the present review include: quality of studies, comparability of studies, and the limited number of studies including the exclusion of 11 due to lack of information sufficient to calculate an ES.

Given these limitations, the finding of a small to medium ES in the present quantitative review and affirmative impressions from our previous qualitative review (Klein et al., 2002) lead us to reaffirm our previous conclusion that the evidence is likely to be more strongly supportive than appears at first glance of a positive relation between congruence and psychotherapy outcome. Orlinsky and Howard (1978, pp. 288–289).) noted, "If study after

flawed study seemed to point in the same general direction, we could not help believing that somewhere in all that variance there must be a reliable effect." A consistent pattern of positive findings is quite unlikely to be explained by study flaws.

Therapeutic Practices

In closing, we offer several recommendations for clinical practice to foster congruence.

◆ Therapists must first embrace the idea of striving for genuineness with their clients. This involves acceptance of and receptivity to experiencing with the client as well as a willingness to use this information in discourse. The congruent therapist is responsible for his or her feelings and reactions and this "ownership of feelings is specified" (Rogers et al., 1967, p. 377). This might include the therapist's thinking out loud about why he or she said or did something. This experiential stance serves an attachment function (bonding) as well as a role function (guides behavior) for the therapy relationship.

◆ Therapists can mindfully develop the intrapersonal quality of congruence. As with all complex skills, this will require discipline, practice and effort. Solicitation of feedback from colleagues, supervisors, peers, and perhaps clients (when appropriate) might also enhance the development of the capacity for relational authenticity.

◆ What can therapists "do" to foster as well as augment the interpersonal experience of congruence? Therapists can model congruence. Congruent responding may well involve considered self-disclosure of personal information and life experiences. It could also entail articulation of thoughts and feelings, opinions, pointed questions, and feedback regarding client behavior. Congruent responses are honest. Congruent responses are not disrespectful, overly intellectualized, or insincere although they may involve irreverence. They are authentic and consistent with the therapist as a real person with likes, dislikes, beliefs, and opinions, as well as a sense of humor. Genuine therapist responses are cast in the language of personal pronouns (e.g., I feel . . . , My view is . . . , This is how I experience . . .).

◆ The maintenance of congruence requires that therapists be aware of instances when congruence falters. Rogers and colleagues (1967) speak of feeling "twisted . . . perhaps I am responding socially, smiling, while actually I know we are avoiding something" (p. 396) and then using the twisted feeling as a cue for the need for self-examination and a return to a more genuine and direct way of relating.

◆ It is important for therapists to identify and become aware of their congruence style and to discern the differing needs, preferences, and expectations that clients have for congruence. Effective therapists will modify and tailor their congruence style according to client presentation (e.g., culture, age, education).

◆ Congruence may be especially important in younger, less educated, and perhaps less sophisticated clients (e.g., adolescents, college students, young adults). The congruent therapist communicates acceptance and the possibility of engaging in an authentic relationship, something needed, but not easily expected from the often formal and authoritarian adults in the lives of these clients.

◆ Congruence appears to be especially apparent in psychotherapy with more experienced (often older) practitioners. Perhaps therapists come to relax the pretense of role bound formality and give themselves permission to genuinely engage their clients as they gain experience, confidence, and maturity. Moreover, experienced therapists may recognize and more carefully discern a client's need for relational congruence.

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References marked with an asterisk indicate studies included in the meta-analysis. The in-text citations to studies selected for meta-analysis are not preceded by asterisks.

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Received September 2, 2010
Revision received September 14, 2010
Accepted September 17, 2010 ■