

A.C. Bohart

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***Commentary on: Existential Psychotherapy in a Deep Cultural Context: The Case of “Keo”***

**Musings on the Case of “Keo” From a Person-Centered Point of View,  
With a Focus on Therapist Responsiveness**

ARTHUR C. BOHART <sup>a,b</sup>

<sup>a</sup> Santa Clara University

<sup>b</sup> Correspondence regarding this article should be sent to: Arthur Bohart, School of Education & Counseling Psychology, Santa Clara university, 455 Guadalupe Hall, Santa Clara, CA 95053  
Email: [arthurbohart@gmail.com](mailto:arthurbohart@gmail.com)

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**ABSTRACT**

In this commentary I will look at the case of “Keo” (Shapiro, 2023) both in terms of recent trends in the field, and from my person-centered point of view. It turns out that these two perspectives overlap.

*Key words:* depression; empirically supported treatments movement; personalization of treatment; therapist responsiveness; existential therapy; person-centered therapy; case study; clinical case study.

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**HISTORY**

***The “Empirically Supported Treatments” Movement***

In terms of recent trends, I want to briefly take us back to the 1990s when the Clinical Psychology Division of the American Psychological Association published its guidelines on the provision of “empirically validated treatments,” ( later “empirically supported treatments,” e.g., Chambless and Hollon, 1998). The empirically supported treatments movement sparked massive controversy in the field, a controversy of which I was a part (e.g., Bohart, O’Hara, & Leitner, 1998). Many objections were raised. Among them: For both many humanistic and psychodynamic therapists a major concern was that therapy was to be a matter of applying standardized treatment packages based on research more appropriate to drug trials than to psychotherapy to clients. Furthermore, therapy was to be based on the use of treatment manuals utilized in these research studies. For many humanistic and psychodynamic therapists, this ran counter to their belief that therapy was individualized to the particular client. It was not a matter of applying a data-driven treatment package to a disorder (see Bohart et al., 1998; Division 32 Task Force, 2004).

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In 2006 the APA Presidential Task Force on Evidence-Based Practice published a statement on “evidence-based practice.” The statement modified that modified the empirically supported treatments mandate to say that evidence-based practice was the combination of using the best available evidence merged with the judgment of the clinician and, most importantly for this article, the unique characteristics and contributions of the client. Nevertheless, the empirically supported treatments approach has continued to be advocated by many, with a continued emphasis on picking a treatment for a client based on two criteria: a) the client’s diagnosis, and b) evidence for it from randomized trials conducted in a particularly prescribed manner. One only modifies the treatment if the treatment is not working.

***Critical Reaction to the Empirically Supported Treatments Approach:  
The “Personalization of Treatment” and “Therapist Responsiveness” Models***

Two trends have emerged to modify the empirically supported treatments approach. These are “personalization of treatment” (Norcross & Cooper, 2021; Cohen et al., 2021) and “therapist responsiveness” (Watson & Wiseman, 2021). Major conferences have had a theme of “personalization,” and major symposia at conferences have focused on responsiveness. What is common to both trends is the idea that one cannot simply apply a treatment to a client based on their diagnosis. One has to individualize the treatment to the particular client, at least to some extent.

The two concepts overlap, but also differ. Although there are multiple conceptions of both (see the above publications), personalization basically has to do with selecting a therapy approach or treatment based on various client characteristics, which can include treatment history, personality characteristics, demographic characteristics, cultural issues, and so forth, as well as diagnosis. Responsiveness is more individualized to the moment. It is most often interpreted as having to do with the clinician’s ability to responsively modify what they are doing with a particular client to meet the client’s needs as things emerge and change in therapy.

The two concepts are obviously related. On the one hand, one could say that responsiveness is one way of personalizing psychotherapy. On the other, there are ways of personalizing that are not based on responsiveness (e.g. Cohen et al., 2021). These are based on the same logic that drove the empirically supported treatments movement: use data-driven methods to identify which treatment to apply to which client. These may include using research-based algorithms for making personalization choices. From my humanistic point of view, there is a mechanistic quality to such approaches that is similar to what many of us objected to as the mechanistic quality of empirically supported treatments.

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By contrast to data-driven personalization approaches, responsiveness is inherently individualized not only to the particular client but to what has been happening in the therapy interaction, and has to do with the therapist’s ability to modify what they are doing in response to the ongoing and emerging context of treatment. As such it is inherently nonmechanized. Research may be used to help the clinician make decisions, but these decisions are data-informed, not data-driven.

Fishman (personal communication, November 10, 2022) has suggested that systematic case history data is particularly valuable for such data-informed decisions. This data is intrinsically contextualized to therapist-client interactions, and thus particularly useful for responsiveness. The purpose of large numbers of case studies of a particular type of therapy situation is to generalize. But one is generalizing from qualitatively, contextually defined situations, not stripping out context as one does in group studies of psychotherapy, especially in quantitative group studies.

As conceived of by Stiles (2021), who is primarily responsible for the development of the concept, responsiveness is actually a property of all human interaction. It is constantly happening as humans interact, as they respond to one another. Therefore, it inherently can never be data-driven. However, that is not to say that a therapist might not use data to help make decisions as how to best respond to the client in the moment.

For Stiles (2021), responsiveness is not necessarily a good thing. For instance, responsiveness in a couple that is arguing could lead the couple towards a higher and higher level of negative interaction, as one person responds to the other’s criticism with their own level of criticism, which leads the first person to escalate their criticism, and so on. As a result, when therapists talk about responsiveness nowadays, they are talking about appropriate responsiveness (Stiles, 2021), that is, responding in a sensitive and facilitative way in the moment to the client’s and the interaction’s needs. When I talk about responsiveness from here on in in this commentary, I will be referring to appropriate responsiveness.

## **APPLYING THE NEW MODELS TO SHAPIRO’S CASE OF “KEO”**

Responsiveness, therefore, has to do with the therapist’s prioritizing responding to the client in terms of what the interaction between the two needs in the moment to move it forward in a positive and facilitative direction. With this in mind, the first thing I want to comment on with regards to Shapiro’s work with Keo is that it is a model of both personalization and of therapist responsiveness. Shapiro’s theoretical model, that of existentialism, is a model of responsiveness in the first place, at least to some degree. But it is not only because the existential

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model is inherently responsive to some degree that the case of Keo is a model of responsiveness, it is also because Shapiro goes beyond his model to respond to the client.

As a model of therapy, existential therapy is inherently personalized and responsive in that the therapist is working with the individual client's subjectivity as well as with what is happening in the here and now interaction (Shapiro, 2023). It is not a "treatment by disorder" approach, because the focus is not on treating a disorder. For instance, Keo presents with issues of both depression and anxiety. However, the focus of the therapy is not on symptom removal. The focus is on helping the client deal with certain existential givens, such as issues of freedom versus security, and intimacy versus alone-ness. Existential therapists believe that helping clients deal with issues of facing up to anxiety, making choices, and creating meaning are the core of therapy. In that regard, existential therapists enter therapy with an agenda, and a "treatment plan" in some sense that focuses their attention on how clients may be dealing with anxiety, avoiding taking risks in favor of preserving security, and so on.

There are references to Shapiro's seeing Keo through this lens throughout the case. A particular example is how Shapiro deals with Keo after a key therapeutic moment, which is when Keo has undergone a ritual with a Kahuna to lift a curse that had been placed on his family. Shapiro focuses on the idea that the curse may have been allowing Keo to not face certain important issues of making choices in the face of risk and anxiety in order to move towards a more positive and meaningful future.

Although the existential model is inherently personalized and responsive in the manner I have described, it is still possible that it could be "applied to" the client in a relatively standardized and mechanized fashion. What is striking about Shapiro's work with Keo is how he does not do this. Shapiro's responsiveness as well as the personalization of treatment is illustrated by how Shapiro responds in culturally sensitive ways to the client right from the start. Shapiro uses pidgin English to communicate with Keo. He is also familiar with Hawaiian terms and uses them with Keo. At the start of therapy, in response to a question from Keo as to whether Shapiro is from Hawaii or not, Shapiro responds, "I wasn't born here. You can tell me if I am a Kama'aina or just another 'dumb Haole.'" Throughout the case Shapiro demonstrates his knowledge and awareness of Hawaiian culture. Furthermore, he demonstrates his willingness to join with Keo and to talk in Keo's language, as well as to seek out further cultural knowledge when need be.

Throughout the case, if it is a clinical task of fitting the client to his existential theory, or fitting what he does in therapy to the unique needs and personhood of the client, Shapiro chooses the latter. The best illustration, in my mind, has to do with the issue of the curse. The curse placed upon Keo's family comes up in session two. Personally, it sounds to me that this may be

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the key issue in Keo's life. Keo has had a rough childhood. He has been in trouble with the law. In his late adolescence and early adulthood he has righted the ship and is on the verge of going to the University of Hawaii. Yet suddenly he gets depressed and anxious, which is why he comes to therapy. At first Shapiro interprets this in terms of the usual existential notions of people being afraid to change the status quo, no matter how painful, and take on new risks in order to make their lives better.

At session two it turns out that Keo has learned that his family has been cursed. Because of this curse he may not be able (in his mind) to marry his girlfriend, play for the University of Hawaii football team, and so on. It is not clear from the case when Keo learned about this curse. Did he learn about this before he came to therapy, but only disclosed it at the second session? Or was he already depressed and anxious, but became even more anxious by the time of the second session because of learning of the curse? Shapiro does not make the timing clear. If Keo learned about the curse before he started therapy, that would explain why he suddenly became depressed and anxious. Otherwise, if he did not know at the time, then Shapiro's hypothesis about Keo's depression and anxiety being due to the new challenges and risks Keo was facing as he transitioned from his old life to his potential new one as a college student, would make more sense.

In any event, when Shapiro learns about the curse at session two, it is instructive as to how he responds. A doctrinaire existential therapist might assume that Keo is using the curse as an excuse to explain his anxiety and to cover over his anxiety about making choices such as marrying his girlfriend, trying out for the football team, and so on (and indeed, Shapiro does hypothesize this). The doctrinaire therapist might try to get Keo to see how the fear of intimacy, new challenges, and so on, were the "real" reason for his concerns over the curse. A doctrinaire cognitive-behavior therapist (I'm particularly thinking of Albert Ellis here) might see his fear of the curse as an irrational belief to be confronted.

However, Shapiro does neither. Instead, being culturally sensitive and responsive, Shapiro takes Keo's fears seriously. The next part of therapy consists of helping Keo decide if he wants to go through a healing ritual with a Kahuna to remove the curse. Shapiro throws himself into this. He consults with experts, including a Kahuna, and helps Keo decide what to do. In so doing Shapiro models appropriate responsiveness, as well as honoring one of the other principles of existential psychotherapy, which is to take the client's phenomenology and subjectivity seriously, and to go with that over the therapist's own hypotheses and theories.

There are other examples throughout the case study where Shapiro places his responsiveness to the client over the theory. When he thinks from his theoretical point of view

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that something is going on with the client, and intervenes along those lines, and Keo does not respond, Shapiro does not press it, but instead goes with the client.

A good example is after the curse is lifted. Shapiro hypothesizes that now that the curse is lifted Keo will have to face the fears that he was avoiding because of the curse. This then becomes his agenda. For instance, Shapiro says that "living under his family curse was protective" (p. 19) and created safety for Keo. Now Keo would have to face the fears he had been avoiding because of the curse. This then becomes Shapiro's agenda. They explore Keo's issues and indeed he does have fears and anxieties that he has to face now that the curse is lifted. However, it does not appear from Shapiro's description that Keo fully does this, and Shapiro does not push him to do that, but stays with the client and goes with the client.

Finally, at the end of therapy, Keo wants to invite Shapiro to a family event. Shapiro says that normally he would decline and not go, but in this case he decides to go because of its cultural importance. Later on, he attends Keo's graduation from college. I would like to note the importance of this from a culturally sensitive point of view. In a research study I and my Latinx graduate students did (Bohart et al., 1994) my students interviewed a number of Latinx clients, several of them from Mexico, at various agencies and found that many of them would be culturally insulted if a therapist was not willing to attend the client's wedding. From the perspective of a culture that is more sociocentric than the dominant northern Euro-American white culture in the United States, my students found that it was more important for the Latinx clients to have their therapist be willing to attend family events such as a wedding than it was for clients from northern Euro-American culture. And, as Shapiro notes, since the connection between therapist and client is one of the important healing elements, it is important to honor this connection. Thus, Shapiro decides to attend these events, and it works out.

Parenthetically, I note that the proscription against doing things like going to a client's wedding is a leftover from early psychoanalytic theory, where the therapist is supposed to stay relatively anonymous vis a vis the client, which has been adopted by many in the mainstream. However, from a person-centered point of view, as well as from other humanistic points of view, we never believed in such proscriptions. To quote what the noted existential therapist and former editor of *The Journal of Humanistic Psychology*, Tom Greening, once said to me, "The only time I treat a client is when I take them to lunch." (Greening, personal communication, circa 2005).

In sum, Shapiro provides an excellent model of therapist responsiveness as well as of personalization.

## **A PERSON-CENTERED PERSPECTIVE ON THE CASE OF KEO**

I want to take a person-centered perspective on the case. In so doing I will both be focusing on aspects of the case that I believe are healing that are not emphasized by Shapiro in his write up (although they are not incompatible with his perspective), but also on some theoretical differences. In exploring the theoretical differences, I do not mean to say that my perspective is the correct one. However, I do have a different take on seeing some aspects of Keo’s experience and offer these in the name of exploring theoretical differences and possible alternative perspectives on a case.

### ***The Person-Centered Perspective***

The person-centered approach holds a different perspective on psychotherapy in comparison to the typical “interventionist” model (Bohart, 2021a). Most discussions of therapy portray the therapist as someone who “intervenes” to fix something in the client (dysfunctional cognitions, conditioned maladaptive responses, lack of awareness of emotions, crippling defense mechanisms, transference, etc.), or to produce some kind of change process in the client. The “force” of change originates primarily from the therapist, even if the client is ultimately the one who does the changing. For the person-centered therapist, the agent of change is primarily the client. The therapist is a trusty sidekick, companion, or listening ear, whose presence supports clients’ intrinsic capacity to take charge of their lives and mobilize their capacity for creative growth. The means whereby this happens is through the therapist and client forming a productive “person to person” relationship. Change is an emergent from this relationship.

### ***The Person-Centered Perspective and Responsiveness***

First, I want to revisit the issue of therapist responsiveness from a person-centered point of view. Even more so than for existential therapy, for which the therapist’s sensitivity to the client’s phenomenological experience and to the here and now relationship between therapist and client are key parts of the therapy, therapist responsiveness is central to the person-centered approach.

One could argue from many other points of view that the key function of responsiveness is to help therapists adjust their “interventions” to the client in order to be effective. That is, if an intervention does not fit with the client, the client’s personality, beliefs, motivations, and culture, it is not likely to be effective. Thus, from points of view like psychodynamic theory and cognitive-behavioral theory, responsiveness is important because it helps the therapist get the client engaged and responsive to the therapy. It, in essence, provides a supportive platform for making therapist interventions work.

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From a person-centered point of view, responsiveness is itself the "treatment" (person-centered therapists don't really see therapy as "treatment," as described above). The primary healing element from the therapist's side of the coin is the therapist's responsiveness. Responsiveness from a person-centered point of view consists of the therapist being a sensitive, empathic responder. One might think of person-centered therapy in terms of the "intervention" of empathic reflections. This is a mis-perception. Empathic responses are not interventions from a person-centered point of view (Bohart, 2021a). Carl Rogers (2002) said that he was not trying to reflect feelings. Rather he was trying to test his understanding of what the client was saying and experiencing. If Rogers was intervening with anyone, he was intervening with himself when he made an empathic response.

For Rogers, therapy was a byproduct of a meeting of persons (Anderson & Cissna, 1997). The therapist's sole agenda is to be responsive and engage in this "meeting of persons." That is the therapy. In terms of Keo, this is a client who has had a chaotic and rejecting childhood, has been mistreated, and has had a rough life. Yet here is a therapist who takes him seriously, seriously enough to work within his culture to help him. Shapiro has engaged in a "meeting of persons." Throughout Shapiro shows his respect of the client by trying to understand and respond to the client in terms of the client's culture. I suspect that it is the client's feeling seen, heard, understood, and accepted, that plays an important role in his therapeutic success, independent of whatever else the therapist has done in terms of helping the client face his fears, etc. Shapiro's willingness to "meet" the client on the client's own cultural turf, and the respect that that shows for the client, I believe, from my person-centered point of view, is one of the biggest "healing" elements in the therapy. It is a prime example of how responsiveness can be healing by itself.

This is not incompatible with an existential point of view. I have noted that Shapiro places responsiveness to the client over his theory. He does not force his agenda on the client. He uses ideas from his theory to probe the experience of the client. In that sense one could say that he is "leading." However, he is also following in that he goes with how the client responds to his probe. In essence, his probes, based on his theoretical point of view, become a way of getting to know and "meet" the client, as well as for getting the client to explore his own experience in his terms, rather than to follow the therapist's agenda.

Now for the theoretical difference. Where I differ from existential theory is in its focus on the client's "avoidance" as a core part of problems. Shapiro repeatedly focuses on Keo's supposed struggle between preferring the stagnation of the status quo versus taking the risks associated with freedom, intimacy, and facing his anxiety in order to venture forward in life by going to college and getting involved in a relationship. Although Shapiro takes Keo's concerns

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with the curse seriously in terms of treatment; it sounds like he also sees it as in part, at least, a way of avoiding facing things Keo must face—i.e. the choices he needs to make to move his life forward, such as fears of intimacy with his girlfriend.

From a person-centered point of view I have two disagreements with this. The first is that we are more purely phenomenological than existentialists are. We work within the client's phenomenology, whereas seeing the client as struggling with fears over intimacy and freedom is coming at the client from an external theoretical perspective. There is nothing wrong with this; it is just a theoretical difference. However, it does lead to some differences in how we approach therapy. We too would work with Keo in terms of what is phenomenologically salient to him—the curse. However, we would do this without speculating as to what else might be going on, such as how Keo may be using the curse to avoid other fears. If there are other issues involved, other fears, we assume they will naturally emerge in their own good time. But we do not assume they are necessarily there.

Second, as I have noted elsewhere (Bohart, 2016; Bohart, 2021b), I believe that theories that assume that clients' problems are based on their avoidance of issues, such as, in this case, seeing Keo's problems as due to his avoidance of dealing with issues of freedom versus security as well as that of being open to intimacy, have the potential of portraying clients as being cowardly and as lacking courage. This is never stated, but I believe this is an implication of such theories (Bohart, 2021b). I believe that the idea that it is avoidance that is the problem can be pathology creating, and point out that it was a key part of my own psychological problems that drove me to therapy in my early 20s. It was my negative self-attribution that I was avoiding taking risks that created much of my anxiety. Furthermore, I have had clients who have reported similar reactions to such ideas.

Of course, most therapists who hold these points of view (psychodynamic, many humanistic therapists, some cognitive-behaviorists) would not agree that they actually see their clients as cowardly wimps. I am certain that Shapiro does not see his clients that way. Yet I maintain that these theories have the potential to imply this.

In accord with this, as therapists are focusing on clients' avoidance, you rarely note therapists commenting on the great courage clients have already shown in digging themselves out of, or at least trying to dig themselves out of, the holes they have found themselves in. Clients have often been adept at confronting pain and fear and continuing to function and try to make their lives better.

Consider Keo. Keo came from an unstable and abusive childhood. He was abandoned by both his father and mother. He was subsequently passed around from relative to relative and

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ended up in the foster care system. He then had several scrapes with the law. Yet by his early twenties he has turned his life around. He has gotten a GED degree, and has done well at a community college. Surely Keo has had to face a lot of fears already in his chaotic life, and yet he has persevered and turned his life around. Far from being plagued with an inability to face fears, I suspect that Keo has shown great courage in getting to where he is now in his life when he comes to therapy.

From my perspective, it is not necessarily Keo's inability or unwillingness to face fears that is the issue. To me the issue may not be so much fears of intimacy, fears of new situations, an inability to leave the "stagnation" of security, and so on. Rather, it may have to do with what is going on along with the fears. I have no doubt that clients do avoid. But as I've tried to demonstrate, they don't always avoid. Most of my clients have already had a history of facing up and confronting fear and pain and continuing to function. So what might be going on?

The issue is usually one of two things: clients (and people in general) avoid when (a) they do not see a sufficiently high chance of success from confronting versus the potential cost—in other words, when the reward of confronting the fear versus the cost is not high enough; and/or (b) when they feel helpless or inefficient (Bandura, 1997). I will present a speculation about Keo as a way of illustrating what I am saying. Of course, I do not know since I did not work with him.

I imagine that in the areas where Keo might be avoiding, the issue isn't so much the avoidance per se as it is a lingering uncertainty about himself, perhaps a sense of incompetence and inadequacy to achieve his aims. If he has fears, they are fears of himself, fears that he would be unable to handle the challenges of the new situations, and these would be reasonably based upon the lack of a "secure base" that he missed in childhood. In my scenario, he might have a lot of doubts about himself, based upon his chaotic childhood and the times when he had gotten himself into trouble. I imagine that he has been fighting against these undermining doubts about himself instilled in him by his prior experiences. He has struggled and achieved some success, so he has partially countered these doubts. But his sense of efficacy is still somewhat fragile.

For instance, there is a suggestion in the case that he had fears about starting therapy. Starting therapy could be seen as fear of the unknown, but we often confront our fears of the unknown, and Keo had already done that in various ways. Why do we sometimes shy away from confronting the unknown? One reason is that we do not see that there is necessarily any profit in confronting it. Keo had no reasons or sense to believe that therapy could help him, and possibly a not unreasonable fear that it could hurt. I think a lot of people shy away from therapy because they think they are going to get moralistically lectured about how they should be, or they think someone is going to tell them there is something wrong with them, or someone is going

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“operate” on them and mess with their mind, or they have other fears. For a male it could be particularly humiliating because of the implication that you cannot stand on your own two feet and solve your own problems, and culturally, it might even be shaming. In other words, they have good reasons for “resisting.” To Shapiro’s credit, he does take this into account and treats the client seriously in this regard.

The second reason Keo might have trouble confronting the unknown of therapy is that his sense of self-efficacy is still fragile. He may feel fundamentally flawed or damaged. He may feel basically ashamed. He may be afraid he is going to learn there is more wrong with him. After all, “therapy” by its very nature, the very word, implies fixing something that is wrong or broken. He doesn’t fear all unknowns—he fears this unknown, maybe realistically, because he has come a long way. Why go into a situation where whatever confidence he has accrued gets undermined by having someone tell him there is more wrong with him (of course, Shapiro does not do this, but Keo does not know this in advance). You have to have some sense of self-esteem, some sense of self-worth, to continue to strive and to live. So he is, in a sense, trying to preserve what resources he has. He has not had enough success experiences to have a clear sense of how to handle stress and adversity.

So that is my theoretical disagreement with existential theory. If my speculation has any truth to it, then it is all the more important that Shapiro be as sensitively responsive as he was. The interesting thing is that, therapeutically, in terms of how Shapiro operates, this theoretical difference does not matter. As a person-centered therapist I would not be speculating about these things as I worked with the client. I would be focusing on understanding the client’s perspective and nothing else. Shapiro does not do anything very much different from what I would have done, although I wouldn’t have done it as well as he because of his knowledge of Hawaiian culture. Shapiro does not force Keo to face the unknown. Rather, compatible with my person-centered point of view, he validates the client’s fears, and, like a good behavior therapist, he goes slowly with the client, letting the client move at his own pace to get more and more comfortable with therapy. He honors the “resistance.” Despite our theoretical difference on this point concerning avoidance, in terms of practice, this brings us back to where I started this commentary. I will end with that—on the importance—and centrality—of therapist responsiveness, no matter what point of view the therapist practices from.

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