An exploration of the person centred approach

Ever since its initial outline by the American psychologist Carl Rogers in his 1951 publication “ Client Centred Therapy: Its current Practice, Implications and Theory”, the Person Centred Approach has attracted much attention, both positive and negative, from academics and practitioners worldwide. I would like to explore the effect this model has had on the world of therapy, society in general and reflect upon its impact on my personal experiences as a counselling student.

The theory was first formulated by Rogers during his many years of clinical work at the Rochester Society for the Prevention of Cruelty to Children in New York State. It was here that he first became aware of the work of the Viennese psychologist and former Freudian protégé Otto Rank and, following a personal meeting between the two men in 1936, Rogers stated that he had become “ infected” with the other mans ideas (Kramer, 1995). Rogers used Rank’s concepts to inform and develop his own theory of non-directive psychotherapy and in 1945 he set up a counselling centre at the University of Chicago. It was while working here that “ Client Centred Therapy” was published and the first outline of the Person Centred Approach appeared. It has, over the years, evolved and been subject to many revisions, not least by its author, but has retained the basic tenets.

In 1957 these tenets were summarised in a paper entitled “ The Necessary and Sufficient Conditions of Therapeutic Personality Change”. These were that the two people involved should be in psychological contact, that the one named the client should be in a state of incongruence and that the second termed the counsellor should be in a state of congruence or integrated in the therapeutic relationship. The counsellor should also experience unconditional

positive regard and empathy for the client and, importantly, try to communicate this fact. Rogers went on to state that “ No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow.” (Rogers 1957)

Within these six conditions, three “ Core Conditions” have been given special significance; these are the conditions or qualities of Empathy, Unconditional Positive Regard and Congruence on the part of the counsellor. Whilst these conditions alone may seem to work well in most counselling situations it is worth noting that unless the first condition, i. e. that of two people in psychological contact is met, it is impossible to build the therapeutic relationship. In cases where, for example, the client has suffered psychotic episodes, or is very withdrawn, contact may be very difficult to obtain. Research into “ Pre-therapy” or the establishment of minimal contact prior to therapy is being carried out by Professor Garry Prouty (updated February 2009) following many years of working with clients suffering from regressive behaviour and psychosis.

The aim of the Person Centred Approach is to create an environment in which the client feels able to undertake the process of self-actualisation or the journey towards a realisation of their own self and worth. This may involve the exploration of many areas of long entrenched beliefs and feelings that may have been internalised but which are not really a true part of the client’s internal locus of evaluation. These beliefs or Introjected values can be so deeply embedded that the client is generally unaware that they are not of his or her own creation, and can cause such anguish and incongruence

that they result in mental turmoil and also physical pain. Rogers believed that we all have a desire for positive regard from significant others, and that this longing results in our acceptance of introjects with the resulting limiting experiences. Using the person centred approach allows for the gentle and respectful exploration of these values with the client progressing at his or her own pace and level.

Underpinning this approach lies Roger’s Personality Theory which, when published in 1951, differed somewhat to the accepted theories of the day.

It took the format of nineteen axioms or propositions and whilst giving a foundation to the theory of the Person Centred approach, also, interestingly, was more about a way of being than a set of rules requiring adherence – each person would and should interpret and live their person-centeredness in their own particular way.

Sanders (1996), in his summation of the propositions state that the core of human personality is constructive and good and that we have an instinctive drive towards achieving our full potential. Rogers called this being “ fully functioning”. He further states that this drive or movement will contain an element of psychological self -healing, that the counsellor must provide the conditions for this to be achieved, and this is best done when there is a complete absence of threat to the client. He concludes by observing that there is no single objective reality but rather a collection of subjective ones and, importantly, the best way to understand another person’s behaviour is to view it from their subjective viewpoint. This humanistic view that the client is at the centre of the healing process, and is master of his own

destiny, is very much at variance with other theoretical models of therapy, such as Behavioural and Psychodynamic.

The Cognitive Behavioural Therapy model (CBT), which is a development of Behaviourism, puts forward the notion that all actions and feelings are learned and so, consequently, can be “ unlearned”. This is achieved by means of recognising when an action is triggered, defining the cause of this, and formulating a strategy to prevent this trigger taking place. Behaviour is broken down into separate elements and each of these elements is then corrected. The primary work in developing this theory of Radical Behaviourism was carried out by B F Skinner who demonstrated that the occurrence of any given behaviour could be made to increase or decrease according to the event which was a consequence of that behaviour. If the event was of a positive nature then the behaviour would tend to occur more frequently; if a negative event followed behaviour then the opposite would happen. He believed that behaviour occurred in a largely mechanical way and that humans are generally reactive. He also believed that the only true scientific approach to psychology was one that objectively studied the behaviour of a client and not the internal mental processes which are, necessarily, subjective. The practice of behavioural psychotherapy was initially begun in 1958 by Joseph Wolpe who, using systematic desensitization managed to teach phobic clients relaxation techniques while they were imagining a stressful event or feared object. These techniques were further developed during the 1960s and during the latter half of the 1970’s the relationship between cognition and behaviour were brought to the fore. A variation of the cognitive therapy, developed by Aaron Beck, is

probably the most widely practiced. CBT has many of the elements of behavioural therapy but also places a greater emphasis on the client's feelings and attitudes. CBT is used for the treatment of a variety of psychological problems including phobias or addictions / substance abuse along with conditions such as PTSD, depressive disorders and para-suicidal behaviour. Gooding and Tarrier (2009) also demonstrate the number of ways CBT can be used to treat the range of problems faced by clients with severe gambling addiction. In a paper to be published later this year they detail the array of techniques and the areas in which they will affect change in the client. These include psycho-education and cognitive re-structuring; the analysis of triggers and risk situations, the acquisition of coping skills; assertiveness training, all designed to help clients to cope with exposure to gambling situations. Tarrier also promotes the use of CBT in the treatment of complex cases. (Tarrier 1998) A clear goal is identified and achieved by small steps, all of which lead to the desired therapeutic change taking place It is often favoured by the NHS over other approaches because it can be seen to break patterns of behaviour and achieve the desired result in quite a short period of time, and is, therefore, considered to be more cost effective. It also fits quite clearly into the medical framework.

The third approach is the Psychodynamic Approach which, in itself, is a development of the psychoanalytical work of Freud. Born in 1856 he completed his medical training in 1881 and, whilst working in the General hospital in Vienna became interested in the use of hypnosis as a treatment for patients who were presenting physical symptoms without an identifiable cause. He noted that the most probable cause of the trouble lay in hysteria

and, since the patients had no conscious knowledge of the root of this hysteria, Freud concluded that the problems lay in the unconscious mind. He then began to devise techniques and carry out clinical interviews which, along with a great deal of self-analysis, formed the basis of his psychoanalytical approach.

He believed that there were three domains of mental activity: the Unconscious, the Pre-conscious and the conscious, each having its own particular effect. The unconscious was, by definition, beyond awareness, but was a major motivatory force in much of everyday life. Freud believed that to gain understanding of this chaotic, illogical area of thought, it was necessary to interpret the symbols it produced, normally in dreams. The pre-conscious domain was mainly a receptacle for memories which although unconscious, can be readily accessed such as names, telephone numbers etc, along with such implicit stimuli as smells or tastes which can influence mood. The conscious domain is where all awareness of thoughts and feelings is held and is governed by logical processes.

He believed that, whether conscious or not, everything we do or say has a goal or purpose and by looking at slips of the tongue for example – Freudian Slips – we could gain an insight into our true desires.

He also devised a structure of personality which, once again, he divided into three distinct areas. The first of these he named the Id; this is a chaotic seething area of desires which is pleasure seeking and amoral, has no values or concepts of right and wrong and is the area that we are born with. The next area is the Super-Ego, which is very much a “ learned” structure which

begins to form when the child is around five years of age. Rules are internalised including the notions of right and wrong, correct and incorrect behaviour and, Freud believed, occurs by identification with the same-sex parent. The final stage is the Ego; this is developed throughout childhood, and acts as a control to the urges of the Id and as a defence against the strictures of the Super Ego. It generally does this by the use of unconscious defence mechanisms.

Although generally regarded as the father of all psychotherapy, Freud's theories have been developed, changed and also denied and ignored by successive generations of therapists. One significant development was the work of Melanie Klein. She was a contemporary of Freud and was the first to focus on the mother / infant relationship and was innovative in the use of the psychoanalytical approach in working with children. She used play therapy to gain insights into her clients and promulgated the view that children spend a great deal of time thinking about and trying to make sense of their early relationships, especially with their mother. She believed that the baby was aware of the mother long before birth and the relationship established very early on. She developed a theory of " object relations", the object being either the mother or even an article such as a toy that could be used as a mother substitute and believed that the baby could " split" experiences into good and bad ones. A bad experience – and that could be, for example, neglect, or lack of nurture – could be carried over to adult life in the form of an impoverished self-concept, whilst examples of good experiences would be carried over to form the basis of self-acceptance.

An interesting aspect of this work is the level of self-awareness required by the counsellor or psychotherapist, particularly in relation to the way they respond to the client. In the Klein model of therapy, it is deemed possible for the client to project strong feelings so that they are experienced by the therapist. This is known as projective identification and can be used as a source of potential information about the client.

There are some major differences but also some similarities between the three psychotherapies detailed above. Person Centred is non-directive, non-hierarchical and considered to be a model that progresses at the clients own desired pace. It can be used in one – to – one setting, or in couple and family groups and is generally, open ended. The person who decides what is best for the client is the client; the counsellor is there to accompany the client on their journey towards self-actualisation. I personally feel that this approach has many qualities to recommend it although, in a medical framework, this can lead to ideological difficulties. As Finke and Teusch (2007) point out, the medical world often sees psychotherapy as a tool to eliminate the patient's symptoms which is greatly at variance with the Person Centred Approach.. They go on to promote a view that, although the traditional PCA is one of contact and relationship with the client, and that the traditional medical framework is one of observation and diagnosis, that there is a way – and indeed a need – for the PCA to exist within the medical framework. This would involve the therapist " oscillating" between the two worlds, sometimes as an observer and at other times as a participant. I believe this is something that needs to be considered if the PCA route is to be made available to other than fee paying clients. Rachel Freeth (2007) raises some interesting ethical

questions concerning person-centred practitioners working within the medical framework and the balancing act they must maintain to avoid compromising their values.

As previously stated the NHS has few fears of CBT as this appears generally short-term treatment, goal centred and results based and so fits quite nicely into the medical framework. I personally know of Kleinian psychotherapists practicing within the medical framework although I have no personal experience of the therapy. The assumption is that it must be cost-effective and efficacious.

There are, of course, other arenas where counselling takes place besides the private practice or within the healthcare framework; within schools, the workplace, hospices and other charitable foundations, residential care homes and in one to one and group situations that deal with such varied themes as addiction, abuse, sexual identity and relationship issues. The regulation of so many varied types and arenas of counselling is upheld by the Ethical Framework, published by the British Association of Counselling and Psychotherapy. It sets out to protect both clients and counsellors by giving clear guidelines and boundaries to be observed. It ensures that counsellors undergo supervision and continued personal and professional development in order to ensure that the quality remains at the highest possible level and vulnerable clients are given the respect they need and deserve.

Whichever model is practiced it is interesting to note that Lambert (1992, 1999), when determining which factors clients believed affected the outcome of therapeutic change, gave an estimated 30% as being dependant on the

Therapeutic Relationship. This was true of all therapies, including those which have a less relational orientation. Mick Cooper (2008) in BACP funded research concludes that different models work for different clients but that the key predictor of positive outcomes is the ability and willingness of the client to make the most of whatever the therapist offers. I believe it can be successfully argued that the basic beliefs of PCT go a long way to ensuring that the therapeutic relationship is of good quality and therefore provides a greater chance of therapeutic change and, subsequently, client satisfaction taking place.

In terms of general society and everyday lives beyond the field of therapy, I believe the implementation of the core conditions of the PCA can be nothing but a force for good; the changes in colleagues attitudes over the length of a course is worth remarking on. Anything that serves to help us understand each other better surely deserves to be encouraged.

Personally, my inroads into the Person Centred Approach have had quite an impact: it has occasioned me to reflect on the journey I am making, question my motivations for my actions and allow myself to begin the somewhat tortuous process of untangling my own knotted past and be given an insight into how I too might achieve self-actualisation. I have grown closer to other members of the group and felt their joy and pain at the discoveries they have made. I have also begun to question the practicalities of adopting a wholly person centred approach; the more I read and experience the more I feel more attuned with a pluralistic approach which suits the therapy to the client – which is, in itself, a very PCA attitude. The lack of hierarchy and the level of care evident in the approach is something that I, as an individual,

find very reassuring and comfortable. It is difficult for me to critically evaluate other models of therapy as I have no direct experience of them; personal prejudice informs that I would feel uncomfortable with a psychoanalytical approach, as I would feel as though I wouldn’t be in control of my therapy. The validity of this is an unknown. CBT has obviously some cost benefits and also shows results very quickly for a wide range of clients with an equally wide range of issues, but it could be argued that a relatively fast therapeutic “ programme” precludes the understanding that is needed for lasting change. In conclusion, I agree with moves to ensure that better research is carried out in all models of therapy so that they are developed in an evidence -based way, and their efficacies made clear; moves supported by the BACP as evident by the work carried out by Mick Cooper and referred to above.

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