The rogerian approach to therapy and its limitations

One of the phrases that Carl Rogers used to describe his therapy is “ supportive, not reconstructive”.

“ It is possible to explain a person to himself, to prescribe steps which should lead him forward, to train him in knowledge about a more satisfying mode of life. But such methods are, in my experience, futile and inconsequential. The most they can accomplish is some temporary change, which soon disappears, leaving the individual more than ever convinced of his inadequacies” (Rogers 1961, p33).

Influences

Rogers never undertook specific training as a psychotherapist (Rogers and Russell 2002, p242), and was initially heavily influenced by his childhood and the restrictions and control exercised by his parents and by an early tutor, Goodwin Watson. Philosophically, Rogers cites Emerson, and in particular Kierkegaard and Buber as his key influences (Rogers and Russell 2002, p169). Psychologists influencing him included Maslow, Combs and Snygg (Nelson-Jones 2000 p99)

Rogers’ belief in an individuals capacity for self-direction “ although primarily founded on his clinical experience…was buttressed by his understanding of Rank’s work” (Rogers and Russell 2002, p9), and he talks of being much influenced by Jesse Taft and Frederick Allen as well as alluding to the work of Karen Horney in his paper on “ newer concepts in psychotherapy” in December 1940.

Theoretical Development

Corey (2001, p170) references Zimring and Raskin's (1992) identification of four definitive periods of development in Rogers approach, commencing in the 1940's with the introduction of ' non-directive counseling'. Corey comments " He caused a great furor when he challenged the basic assumption the " the counselor knows best"…Based on his conviction that diagnostic concepts and procedures were inadequate, prejudicial, and often misused, he omitted them from his approach". During this time Rogers placed emphasis on a permissive and non-directive climate aiming to gain insight into client feelings.

During the second period, Rogers shifted focus from the therapists approach onto the phenomenological world of the client. The clients' internal frame of reference and the actualising tendency as the driver for change received attention, with the approach subsequently being renamed ' client-centred therapy'.

The third period observes Rogers further refine his approach, focusing on " the nature of " becoming the self one truly is"" (Corey p170), or the " necessary and sufficient conditions of therapy" as outlined by Rogers in his article in volume 21 of the Journal of Consulting Psychology in 1957 (Kirschenbaum and Henderson p 219-235), in which he explains his hypothesis for a set of facilitative conditions related to psychotherapeutic change. Rogers also undertook extensive research into the client / therapist relationship at this time.

The final stage outlined is 1970 onwards when the focus became far broader, encompassing education, industry and world politics, subsequently becoming the ‘ person-centred approach’.

Rogers’ early work in counselling and psychotherapy therefore outlined new concepts in the world of psychotherapy suggesting a new way of viewing the therapy relationship. These developments resulted in the formulation of a non-directive approach with an emphasis on the present rather past, feelings rather than thoughts and focussing on the clients rather than the therapists’ resources. This led to a supportive therapy relationship, which Thorne (1992) believes Rogers maintained as key to the therapeutic process throughout his life.

“ the whole conceptual framework of Rogers’ ideas rests on his profound experience that human beings become increasingly trust-worthy once they feel at a deep level that their subjective experience is both respected and progressively understood” (Thorne 1992, p26)

Key Concepts

In a 1957 article in the Journal of Consulting Psychology, Rogers listed the conditions of the therapeutic process in which such an atmosphere can come about.

“ For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

Two persons in psychological contact

The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious

The second person, whom we shall term the therapist, is congruent or integrated in the relationship

The therapist experiences unconditional positive regard for the client.

The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.

The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

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." (Kirschenbaum and Henderson p221)

Stedman's provide a medical definition of Supportive psychotherapy as " psychotherapy aiming at bolstering the patient's psychological defences and providing reassurance, as in crisis intervention, rather than probing provocatively into the patient's conflicts" and in consideration of this the above conditions can be interpreted as a framework for the provision of a " supportive" environment for the therapeutic process.

Therapeutic Process

The case of Mary Jane Tilden, seen by Rogers in 1946, is noted by Patricia Raskin (1996, p135) as being an “ excellent example of the classical Rogerian approach”, subsequently being subject to review from both client-centred and contemporary psychoanalytic viewpoints.

The case of Mary Jane involves a withdrawn woman of 20 brought into therapy by her mother, seemingly struggling to break free from the influence of others and to resolve deep internal conflicts, apparently having tried but repeatedly failing to pass through the adolescent stages of life into maturity. Rogers had a total of 11 sessions with Mary Jane, during which marked changes are seen to take place, particularly in the later sessions when more rapid change becomes evident.

Throughout the early sessions Rogers continues to support, recognise and clarify feelings even when the client portrays an extremely bleak outlook, making repeated references to sanatoriums, inadequacy, comparison to others and even mentioning suicide and possible brain damage. Mary Jane repeatedly tries to place ownership onto Rogers, asking many questions and seemingly becoming quite frustrated at his refusal to provide answers. Rogers refuses to supply answers whilst consistently remaining empathic and supportive. In the third session we see Mary Jane pushing for answers but interestingly on this occasion when left to her own thinking she works out the answer for herself.

Reviewing the Mary Jane case Dingman (1996) considers that Rogers consistently refrained from providing the answers or strategies repeatedly requested, or to provide advice or guidance choosing instead “ to remain

emphatically present, to understand her frustration and confusion without prescription for change… [and] would not undermine Mary Jane's movement toward encountering fully the " what I am" by providing answers" (Farber Brink and Raskin 1996, p202).

Although tentative moves toward improvement in earlier sessions are apparent, a definite step change is noted during session seven as Mary Jane recognises her internal conflicts. Lengthy pauses prevail as Rogers allows time for independent information processing and solution identification. In session eight the realisation of her parents influence becomes apparent however the hopelessness is now clearly interspersed with awareness, insight and tentative positivity.

Dingman proposes " within the empathic enclosure that Rogers provided, Mary Jane's introspective, intellectual interest in self shifted slowly to more primary experiencing" (Farber Brink and Raskin 1996, p202).

Geller and Gould (1996) acknowledge Rogers achieved success in strengthening Mary Jane's " capacities for autonomy and mutuality" and that she had become increasingly self-accepting, but argue " Rogers and Mary Jane never did achieve full agreement on the goals of treatment, their relative responsibilities or the kind of relationship required to do the therapy work" (Farber Brink and Raskin 1996, p218). They argue Rogers responded to Mary Jane's strengths but was neither empathic nor perceptive about her more negative feelings, failing to address unconscious conflicts and therefore potentially limiting the depth of her explorations in these areas.

They question whether follow through would have produced more enduring gains.

Accelerated change is observed during the last few sessions, with Mary Jane confronting dependence issues. Although still asking questions she no longer pushes for responses, instead progressing to answer independently. In the final session Mary Jane speaks of progress made and changes experienced, noting that it has become easier to talk with more reliance on instinct and an ability to “ act natural”. Raising concern improvement may be temporary, she nonetheless appears confident that she now has the ability to cope.

Considering Mary Jane’s “ movement toward adjustment”, Dingman refers to the necessity for resolution of all her preconceived notions of what she ‘ should do’ and ‘ should be’ prior to ceasing to resist and so shift toward acceptance of “ what I am”, stating “ Evaluation, comparison, analysis, the longing to be what one is not – all this had to die for the new “ living pattern” to emerge.” (Farber Brink and Raskin 1996, p208)

In reviewing Rogers’ management of the case, Geller and Gould comment “ Rogers style of working can be viewed as essentially directed toward helping Mary Jane forge a cohesive sense of self, capable of individuation…Rogers primary aim was to support the development of the client’s unique individuality and expressiveness” further stating the belief that Rogers approach did promote therapeutic change in Mary Jane through “ consistently providing…empathic responsiveness tempered by optimal frustration”, remaining non-judgemental and through a refusal to provide answers or to provide guidance or reassurance thus forcing Mary Jane to

take “ increasing responsibility for her own life”. (Farber Brink and Raskin 1996, p224)

Geller and Gould state the classical psychoanalytical view that reconstruction was paramount to the therapeutic process, noting that this view has since evolved to recognise the role of the relationship and concluding that “ Carl Rogers demonstrated, 20 years before the current popularity of short term psychodynamic psychotherapy, that it was possible to achieve ambitious therapeutic goals within a relatively short space of time” and believe that “[Mary Jane] did create some enduring internalized representations of Rogers’ warmth, support and helpfulness”. (Farber Brink and Raskin 1996, p228)

The case is therefore a good example of Rogers not deconstructing the past to effect reconstruction, consistently remaining supportively and empathically present. Mary Jane, rather than the therapist, carried out independent deconstruction with subsequent disintegration of all analysis and previous structure before progression toward a reconstructed self resultant from a supportive and empathic relationship.

Reconstructive Therapy

In understanding the term reconstructive therapy Stedman’s definition is considered:

“ a form of therapy such as psychoanalysis, that seeks not only to alleviate symptoms but also to produce alterations in maladaptive character structure and to expedite new adaptive potentials; this aim is achieved by bringing

into consciousness an awareness of insight into conflicts, fears, inhibitions, and their manifestations".

Sperry states " supportive psychotherapy is differentiated from reconstructive psychotherapy" and considers the goal of reconstructive psychotherapy " is to work through the abandonment depression... This leads to the achievement of ego autonomy and the transformation of split object relations into whole object relation and the split ego into a whole ego". Supportive psychotherapy is noted as being less intensive and regressive. (Sperry 2003, p97)

To achieve deeper understanding of differences between reconstructive and Rogerian therapy, Interpersonal Reconstructive Therapy is considered. Benjamin states " therapy starts with learning to recognise your patterns, where they came from and what they are for" (Benjamin 2006, p21), considering problem behaviours and associated symptoms represent attachment centred around dysfunctional relationships with important persons in early life, referencing Bowlby's 1977 assumption that important early relationships provide " internal working models" for a child. Benjamin explains " The linchpin of IRT...is the process of coming to terms with important persons and their internalised representations (IPIRs)...coming to terms compares to working through in traditional psychodynamic therapy" (Benjamin 2006 p73).

In total contrast to the Rogerian approach, IRT is structured and directive, aiming at reconstruction and is configured of five sequential steps commencing with the identification of patterns. Movement through a

deconstruction stage relying heavily on regression, before progression through a reconstruction process leads to final embracing of change. “ The goal is that the impossible wishes that support the quest for psychic proximity to the IPIRs must be recognised, grieved for and given up. Then reconstruction of personality can begin” (Benjamin 2006 p326)

Research

Basavanthappa (2007) considers Supportive therapy to be “ the most widely practised form of individual psychotherapy today”, and on review of the Mary Jane Tilden case there is seemingly agreement that Rogers’ supportive approach successfully achieved a positive outcome. To quantify these opinions research evidence is explored, prior to consideration and discussion of any potential limitations a strictly Rogerian approach may present.

Two independent studies (Friedli et al 1997; Bower et al 2000) based on randomised, controlled assessment “ concluded that person-centred, non-directive therapy more than holds its own compared with other forms of therapy”. (Feltham and Horton, 2006, p296)

Analysing the outcome of The Menniger Psychotherapy Research Project carried out in the 1950s, Howitz (1974) suggested that “ patients...did improve significantly in supportive therapy, given the achievement of a powerful therapeutic alliance”. (Fonagy, nd). Reanalysis by Wallerstein in 1986, reported on the long term follow up (Fonagy, nd), and Sperry (2003) states the report outcomes “ suggest that supportive treatment is able to bring about the basic personality changes that were expected only from reconstructive dynamic psychotherapy”, before concluding “ despite

Kerbergs (84) characteristic of Supportive Psychotherapy as a “ treatment of last resort” Supportive Psychotherapy is a potent intervention”. (Sperry 2003, p98)

The Hamburg study (1981), involving comparison of client-centred and psychoanalytic therapy, concluded “ In direct comparison of psychological test scores between cct and pt groups, few significant differences emerged and none of those that did were replicated in subsequent analyses.” (Fonagy nd, p301).

Cooper (2008, p128) notes that psychotherapy researchers such as Lambert have estimated that relational factors account for around 30% of the variance in outcomes whilst technique and orientation factors may contribute only 15% toward overall outcome of therapy with Wampold (2001) calculating a much lower figure of only 1%. Furthermore, the Task Force of the Psychotherapy Division of the American Psychological Association, found ‘ demonstrably effective elements’ for positive therapeutic outcomes to include empathy (Bohart et Al 2002) and ‘ promising and probably effective elements’ to include positive regard (Farber and Lane 2002) and congruence or genuiness (Klein et al 2002) (Feltham and Horton, 2006, p67).

Research by Bohart and Tallmand (1999: 51) concluded “ from a client perspective, the most important aspects of therapy typically are the “ non-technological” factors: having a time and place to talk; having someone care, listen and understand; having someone provide encouragement and reassurance; having someone offer an external perspective and advice” (Cooper 2008, p99). These findings reinforce Heine’s 1950 study quoted by

Rogers (1967) concluding that regardless of therapeutic orientation it was the attitudinal elements in the relationship that accounted for positive outcome. These include trust felt in the therapist, being understood by the therapist, the feeling of independence they had had in making choices and decisions and therapist ability to clarify and state feelings. Elements found to be unhelpful included the giving of direct specific advice or emphasising past history rather than present problems.

Cooper concludes that " the quality of the therapeutic relationship is closely associated with therapeutic outcomes across both relationally and non-relationally orientated therapies" (Cooper 2008, p120).

On review of empirically supported treatments subjected to rigorous experimental studies against specific forms of psychological distress, Cognitive Behavioural Therapy (CBT) is repeatedly presented as a treatment of proven effectiveness (Cooper (2008) p38-45), consequently being adopted by the National Institute for Health and Clinical Excellence (NICE) as a treatment of choice for many psychological disorders. Cooper notes, however, that the lack of evidence does not correlate to lack of effectiveness pointing out the need for further research to support the effectiveness of other therapies.

In summarising technique and practice factors, Cooper considers that although there is little evidence to support the effectiveness of one technique over any other, CBT has the strongest evidence base, particularly for anxiety related issues. Cooper also suggests that although there is evidence to support directive and non-directive methods extremes of either

should be avoided. Humanistic techniques, when undertaken effectively and with the result of “ deepening levels of experiencing and emotional processing” can be linked to positive therapeutic outcome. (Cooper 2208, p154)

Research by Glass and Arnkoff (2000) suggests that a collaborative approach is favourable, and whilst the above research promotes the effectiveness of CBT, Kirschet al. (1995) found “ hypnotic procedures have been found to significantly enhance the efficacy of CBT” (Cooper 2008, p174). One such model taking this approach is presented by Assen Aladdin in his Cognitive Hypnotherapy model, with Aladdin quoting research studies by Schoenberger (2000) and Kirsch, Montgomery and Saperstein (1995) as concluding that hypnotherapy was found to be significantly superior to non-hypnotic treatment when combined with CBT (Aladdin 2008, p10).

Limitations

Considering limitations of the client-centred approach Corey (2001) quotes feedback from an exercise by Cain (1988):

Person centred therapy is too simple.

It is limited to techniques of attending and reflecting.

The approach is ineffective and leads to undirected rambling by the client.

Rather than emphasising the counsellor as a person, it would be better to focus on developing a variety of techniques that can be applied to solving specific problems.

More emphasis should be placed on systematic training of counselling skills and less on the attitudes of the counsellor.

It is not necessarily true that individuals have within them a growth potential or actualising tendency.

Not all clients have the capacity to trust their own inner direction and find their own answers.

(Corey 2001, p186)

In reviewing the above, one could question whether these represent the failings of the approach if carried out incompletely than in the method originally intended by Rogers. Indeed, prior to this Corey comments “ Therapist authenticity and congruence are so vital to this approach that those who practice within this framework must feel natural in

doing so … If not, a real possibility is that…therapy will be reduced to a bland, safe, and ineffectual pabulum”. (Corey 2001, p185)

By nature, the purist Rogerian approach is heavily dependant on the therapist and their abilities to meet the conditions Rogers considered essential to ensure “ necessary and sufficient conditions of therapy”, and therefore the extent to which the outcome is also dependent on the therapist has to be questioned. On reviewing the nine case commentaries in ‘ The Psychotherapy of Carl Rogers – Cases and Commentaries’ (1996), it becomes apparent how inconsistent Rogers approach can appear, with notable changes in both his style and approach between clients, not only indicating

the importance of therapist ‘ ability’ but further questioning the extent of therapist influence on the process.

Research by Sasche(2004) concluded “ that clients are not particularly good, by themselves, at deepening their levels of processing” and that “ they are strongly influenced by their therapists statements” Sasche explains that ‘ deepening’ statements conducive to more productive therapeutic work are actively achieved by the therapist through reflection at a deeper level, with ‘ flattening’ statements reflecting back at the same or shallower level producing more superficial client processing (Cooper 2008, p141). This suggests the therapist is therefore very much in control of the therapy process, even in a non-directive approach.

Whilst it is evident on study of Rogers cases that he frequently encourages deepening of experience in the way that his ‘ reflection’ is carried out, he also appears to subtlety challenge clients in the process. Corey (2001, p185) notes that many therapists fail to achieve this and that they have “ limited the range of their responses and counselling styles to reflections and emphatic listening” becoming “ client-centred to the extent that they diminish the value of their own power as a person and thus lose the impact of their personality on the client”

Conclusion

There is considerable research evidence suggesting the importance of the therapeutic relationship, and moreover to the specific qualities of empathy, positive regard and congruence all of which are pivotal to Rogerian therapy,

however further empirical research is required to enable links to positive outcomes for specific psychological issues.

“ research evidence that the therapeutic conditions are both necessary and

sufficient is not unequivocal, though much of it suffers from inadequate methodology and the possibility of poorly reported and discussed reports… this research forms the basis of the mainstream view…that the therapeutic relationship is the key factor in successful outcome”. (Feltham and Horton 2006 p296)

Whilst the relationship is evidently key for a positive therapeutic outcome, utilising relationship alone relies solely on therapists’ ability to emulate Rogers intended approach. It is logical to assume this is likely to produce more inconsistent results than a structured therapy integrating the Rogerian approach could achieve. There is also evidence to suggest that extremes of either directiveness or passiveness are detrimental and also that a collaborative approach is the most appropriate intervention in ensuring a positive outcome.

A feasibly conclusion can be drawn that a collaborative approach (Glass and Arnkoff 2000) combining a relationship comprising empathy, positive regard and congruence (Task Force Study) with CBT (Cooper 2008) and enhanced by hypnotherapy (Kirsch et al 1995) could hold the potential to provide a consistently effective and positive therapeutic intervention in the alleviation of psychological disorders with further empirical research needed to prove efficacy for specific forms of psychological distress.