The Person-Centred Approach to Therapy

Dave Mearns:

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In this session I would like to focus on the rationale underlying the Person-Centred approach to therapy. I will not go into too much detail on the rationale since this audience is likely to be reasonably familiar with much of it. I would like to spend more time trying to explode some of the common myths about the person-centred approach. Finally I will look at some of the basic skills involved and consider the nature of training/development implicit in the person-centred approach.

First I would like to say a word about the name: "person-centred approach to therapy". In the very early days the name was "non-directive therapy". While the use of this name reflected its emphasis on not directing the client towards particular conclusions or decisions, it really was a gross misuse of the English language: there can be no such thing as "non-directive" therapy since any therapeutic intervention will, to some extent, and in some manner be directive. Having said this it would be fair to think of the person-centred approach as "less directive". The next name used was "client-centred therapy".This was a much better label since it emphasised that the process of the therapy was centred in the experience of the client, and its use of the term "client" rather than for instance "patient" reflected in its connotative meaning the fact that this approach emphasised the importance of respecting the other person. In more recent times the term "person-centred approach" had been adopted chiefly since the approach now has applications not just in therapy, but in other areas such as education and management. One label which is not appropriate, but which is often used, is "Rogerian" therapy. This is a particularly bad label to use since it tends to imply that a therapist need only model himself on Carl Rogers to obtain success as a person-centred therapist.

This is not only ridiculous, but indeed, runs totally counter to the emphasis which the person-centred approach places on helping the individual trainee to develop along lines which fit his own self. Carl Rogers is not the most person-centred therapist I have ever met, but he is, without questions, the best Rogerian!

Rationale of the Person-Centred Approach

The basic hypothesis of the person-centred approach is that potentially the person who can best understand and change the client is the client himself. The task of the therapist is to create the conditions where the client feels free enough, strong enough to do that.

The obvious advantages of this emphasis on the centrality of you, the client, are that:

1. Your "solutions" are more likely to be the ones which fit you.
2. You are more likely to be able to act upon your own decision than any of mine.
3. A longer term, "social educational", effect is that having seen yourself come to your own solution and act upon it you may be more able to do the same for yourself on future problems.
4. Another even more basic part of the rationale for this focus on the "reality" of the client is that often there is no other way that therapy can meaningfully proceed (this would be particularly obviously

true in the case of the psychotic client whose reality is totally different from that of the therapist.)

The following are some of the "conditions" which the person-centred therapist is trying to establish in the therapeutic relationship:

1. He is trying to push the client towards being his own locus of evaluation. Often a client's locus of evaluation is outside himself: he does not feel powerful in determining his own behaviour; he evaluates himself solely in terms of the feedback he receives from others, or in terms of earlier, perhaps parental, "messages" about what he is like.
2. The therapist accepts the client as a person of worth, and communicates this acceptance. This is quite easily said: indeed it sounds quite glib, but it implies a considerable amount of development on the part of the therapist to come to the point where he genuinely feels accepting towards others. It is important to note that acceptance does not imply approval: I can accept someone as an important, unique human being without necessarily approving of all his actions.
3. Empathic listening is not only a means of the therapist checking out his insight into the client's world of experience, but it encourages the client to explore this world further, and communicates to the client that he can be understood.
4. Possibly the major construct which should be applied to the therapeutic relationship is trust. The therapist is trying to establish a relationship in which mutual trust exists. Here we are talking about creating a situation where the client trusts the person who is the therapist, rather than simply trusting the role of the therapist. Even from very early on in the therapy the client will often trust the role of the therapist: in other words he predicts that "because this person is in this helping role I can trust him". The trust which the person-centred therapist is trying to establish goes far beyond this: he is wanting to create a situation where the client trusts him as a person and not simply because he is a "therapist". The other part of the mutuality of trust, i.e. the trust which the therapist feels for the client is also important less the therapist become wary and defensive towards the client. The quest after this part of the trust demands a commitment on the part of the therapist to bring into the open any fears or anxieties he has in relation to the client, insofar as these are persistent and increasingly damaging to the therapeutic relationship. While once again both aspects of this mutual trust can be quite easily described on paper, it can be a long patient struggle with paranoid clients or the client who feels that other people are "not OK.". Perhaps even more demanding than this is the commitment the therapist must have to bring into the open difficult issues towards which he may otherwise have become defensive.
5. An extremely important therapeutic condition is that the therapist does not draw the client into his own (the therapist's) psychological games. The meeting of this condition demands that the therapist become aware of the games he is likely to play and the way he is likely to play them in therapy.
6. The previous condition may be a special case of the therapist's congruence in relation to the client. There are two forms of incongruence:
    a. incongruence between the therapist's feelings and his awareness of those feelings.
    b. incongruence between the therapist's awareness of his feelings and his expression of those feelings.

Reduction in the first form of incongruence demands self-knowledge on the part of the therapist, not just during initial training, but throughout the working life of the therapist.

The second form of incongruence resembles more a lack of genuineness in that it is conscious: the therapist is consciously hiding his feelings and trying to disguise his reactions. The result is likely to be that he communicates double-messages to the client: for instance, gentle words said in a controlled slow, quiet manner with the odd lapse into a biting word or tone of voice to indicate the anger which the therapist is trying to mask. A common source of the second form of incongruence arises from the therapist trying to appear "professional" in relation to his client. Such a "professional facade" is anti-therapeutic to the person-centred therapist. It is amazing how often helpers in our society are hoping that the client they are working with can attain his wish to become more straightforward, open, congruent, less guarded, and less afraid of what others may think of him. And we try to do that by putting on a "professional facade" and so present to him a model of less straightforwardness, less openness, incongruence, a more guarded individual, scared to be seen without that professional "mask".

At its heart, the person-centred approach is an attitude rather than a set of behaviours. The therapist cannot simply adopt a set of person-centred behaviours and expect to be operating in a person-centred manner. The incongruence of such a display would be self-defeating. Nor is it simply a matter of saying "I'll try the

person-centred approach with this client." It is not an attitude which can be "tried." The element of "trying" would inevitably come over to the client; also it is unlikely that you would last through all the difficult parts of the process where tremendous patience is necessary.

Any attitude has three components:

a. The "affective" (feeling) component. This is tied in with the person-centred therapist's faith in the process of therapy which helps the therapist to "hang in" through all the conflicts, boredom, times of little movement, and despair, which may be part of the therapeutic process. Less experienced therapists find this more difficult since their faith in the process has not yet been developed through experience.

b. The "cognitive" (knowing) component of the attitude is represented by the therapist's knowledge about the factors which enhance or diminish his ability to be person-centred i.e. his self-knowledge.

c. The "behavioural" expression of the attitude relates to the therapeutic skills of the person-centred therapist.

I shall go into some of these skills later, but first I would like to explode some of the myths attributed to the person-centred approach.

Myths

Carl Rogers was reluctant to come to Britain (indeed his first visit was in 1978 when he was 76 years of age). His reluctance was particularly related to the fact that he did not think the British were particularly interested in the person-centred approach to therapy or education. Not only were the sales of his books much lower than in other European countries, but more important than that the book reviews he had had in Britain, while they were mainly positive, were also in his view pretty unsophisticated. I have also been frustrated by this lack of understanding of the complexities of the person-centred approach which I have found quite prevalent in this country. I am fed up hearing people describe the person-centred approach as: "oh, that's where the therapist just sits passively and does not do anything". I would like to take this opportunity to try to explode some of these myths.

Myth 1: "The person-centred approach is passive"

This view of the p-c approach may be due to the fact that empathy is one of the key concepts. Since empathy implies listening and giving the other person space, the therapist may appear "passive". However, listening is by no means a passive activity: not only is it dammed hard work to pick up not just the surface meaning, but also the depth meaning in the client's expressions (just try focusing at levels eight or nine on the Carkhuff scales for any length of time with a client), but listening demands the therapist actively refrains from interfering with the process by slipping in his own interpretations. It is amazing how seldom we do really listen to a client: so much of our time we spend thinking about his problem, and trying to come up with "clever" things to say. Neither does listening mean being totally silent: listening demands that we check out our understanding, and in so doing communicate our success or failure in comprehension. Listening is an active process.

Myth 2: "The person-centred approach is non-directive"

This can be directly related back to Rogers' early writing before about 1950. As I have said earlier he used the term incorrectly, but as a means of emphasis. The person-centred approach is less directive than many other therapeutic and educational approaches, but there is no way that it is non-directive. Any form of intervention has a degree of directivity. (If we were in a restaurant and someone at the far end of the room broke down in tears and distress, and if we stayed exactly where we were and waited until the person got themselves together, then we would have been totally non-directive!)

Myth 3: By the same token person-centred therapy is not "value-free".

Michael Polanyi in his magnificent book on the philosophy of science entitled "Personal Knowledge", clearly explodes the myth of "value-free" sciences. Similarly the person-centred approach is not value-free. When I say to my client: "I see that you have been really torn by three quite different alternative courses of action: leaving your husband, staying with him, or ending it all". That statement may sound "non-directive" in the sense that it is not pushing one particular course of action, but it is directive in the sense that it is pushing the client to review the alternatives. Neither is it "value-free" - far from it - it clearly communicates an openness on the part of the therapist to give consideration to all three alternatives expressed by the client, hence giving expression to the values: "it is important that I be open to the way my client construes his problem", and "it is not my place to manipulate my client towards particular solutions which may be preferred by me". Do not mistake these values as being value-free.

Myth 4: An extension of this is the assertion that the person-centred approach is "good because it is non-political"

While it is certainly true that the person-centred approach does not fit neatly into any of the political parties in this country, it is most certainly not a-political. The following are just a couple of the political hypotheses implicit in the person-centred approach.

a. "If you accept other people they are more likely to be able to accept themselves and others."

b. "If you are consistently genuine with other people they are more likely to begin to value genuineness in themselves and others." Imagine what these would mean to society if they were given widespread expression. Far from being a-political, the person-centred approach is revolutionary, albeit a "quiet" revolution.

Myth 5: "being congruent" does not imply total and unswerving openness

Imagine what a therapy session would be like if we had to express every single feeling which drifted through us whether or not it was related to the client, and regardless of the strength of the feeling. There would not be much space left for the client. "Being congruent" means being sufficiently self-aware and open to express feelings which relate to the business of the client or our relationship with him, and which are relevant to the client and/or the therapeutic relationship. Often students ask me: "but surely you don't always tell your client when you are angry with him?" My answer is "no, I don't always, and sometimes I do". Sometimes my "anger" is a passing rather than a persistent feeling, and even sometimes when it is persistent and really strong, my client is heavily involved in something else and my anger is not appropriate at that time, but should come out later, if it endures, else the relationship will be threatened. (We could borrow from Gestalt here to diverge into the fact that "my anger" is truly mine and nothing to do with the other).

I want to move on to "skills" now, but just in case anyone still holds any myths about the necessary passivity, non-directivity, or for that matter the "gentility" of the person-centred approach, I have lifted, out of context, some therapist statements to clients:

- "I'm really pissed off at you - no I am not pissed off, I fucking angry as hell at you.'"

- "Almost all of this session you've really been getting up my nose - you've been whining all day about how everything is everyone else's fault and nothing to do with you".

- "You seem intent on getting me to admit that you are a hopeless case - that you are no good at anything - and you're damn near succeeding."

- "I am really scared of you."

- "Why don't you tell him to fuck off?"

- "You owe me £50.00 for our last series of sessions."

These are not necessarily anti-therapeutic to the relationship, indeed the opposite may be true. Although if they are not followed up by the therapist some of them may be anti-therapeutic.

(I hope that I haven't now created the myth that to be a person-centred therapist you must use bad language!)

Skills

To my mind the most unfortunate thing which Rogers ever said about the client-centred approach to therapy was that some people are that way without training or any formal educational background. The problem with this is that for every person to whom it rightly applies there are another 1000 who think it applies to them. ("I can do that - I am that way anyway - I don't need training/development").

Being able to be in relation to someone in such a way that I tune into their way of viewing the world and try to find ways of helping them to explore and test their reality, without my own fears, hopes and defensiveness obstructing that process is the most dammed difficult thing I have ever tackled. To do all this in such a way that the person goes away rightly attributing his "movement" to himself and not to me involves so many skills that learning and developing them is a never ending road on which I am near the beginning.

I will pick out some of these skills and make some comments (some personal, some theoretical) about them. I have not tried to put the skills in any particular order of priority.

1. Less-defensiveness.

   Therapist defensiveness is one of the biggest blocks to the therapeutic relationship. In perceiving the behaviour of our client as some sort of threat to us we sometimes defend our view of ourself and his view of us by means of a variety of defensiveness responses such as: making sure that he is aware of our status, expertise or authority; by putting him down in some way; by making it clear to him that our continued acceptance of him is conditional upon his behaviour towards us; by putting him in double-bind; or by the many other subtle ways that there are of preserving our self esteem by diminishing the other. Important personal knowledge here for the therapist is: what situations tend to spark off my defensiveness; what forms does my defensiveness usually take; and what are its usual effects on other people and my relationship with them. Thereafter the development process for the therapist would involve his gradual experimentation with less defensive means of response in these situations. (It is important to note that such programmes of therapist's self development will not just take place in his therapeutic relationship, but also in his wider relations with others. It should also be noted that taking on too many developments at once can have a paralysing effect). The movement towards less defensiveness gains pace when the therapist begins to realise that he does not need to defend himself. Nevertheless, there will still be many times when we are "taken for a ride" - perhaps we should begin to worry if we are never taken for a ride.

2. Developing a less-judgemental attitude.

   It is easy to say that therapists are not paid to adopt the role of moralists yet we will all have our own personal thresholds in terms of how far a client can deviate from our personal value system before we want to judge him. The skill of the therapist is to gradually raise his personal threshold so that there are fewer and fewer situations in which he will respond in a judgemental fashion.

3. Empathic listening.

   In many ways this is the easiest skill to develop: several hours every week analysing tapes of our therapy sessions in terms of the empathy scales will almost certainly increase our skill in empathy. This is not to say that practice alone develops skill in empathy: to pick up and identify the feelings of others we have to be pretty "centred" and peaceful in ourselves. An analogy with tuning-forks might hold some water: when we bring a tuning-fork up close beside another which is vibrating on the table our tuning fork will begin to pick up the vibrations of the other, and resonate with it. If our tuning-fork is disturbed by its own independent vibrations the message it receives from the other will be highly distorted. If, while we are trying to understand the feelings of others, we are "vibrating" with our own wishes, fears, anxieties, memories of our previous experience, or interpretations of the other, we are unlikely to be able to form an uncontaminated picture.

4. Stereotype "bashing".

   Insofar as stereotypes make assumptions about what members of the stereotyped group are like they can get in the way of our accurate understanding of our clients. For this reason it is important in therapy to view the client as an individual uncontaminated by any therapist stereotype. Developing this skill often involves the therapist in identifying the nature of his stereotypes, and also the strength with which he holds these stereotypes. Thereafter he may enter into some stereotype "bashing" in order to reduce the strength of particular stereotypes. These may be ones which are particularly strong for him, or stereotypes about groups with whom he is expected to work. Stereotype "bashing" involves the therapist maximising his contact with members of the stereotype group. Stereotypes rarely stand up in the face of lengthy personal experience.

5. Self awareness.

   Here we are not talking about the inclination to strive after self awareness, but the discipline to review regularly the way we are in relation to clients and the ability to objectify and look at self. This skill of self-objectification is best carried out in relation to a supervisor. The ideal supervisor is probably someone with whom we can share our innermost fears and doubts; someone who is not afraid to confront us; and someone who is neither dependent on us, nor we dependent on him.

6. The ability to risk being genuine.

   It is easy to say that we should be genuine in relation to our clients, but sometimes it is extremely difficult to "take the risk" of genuineness. Often when we have not been genuine we rationalise our lack of genuineness in terms such as: "It was better for my client that I be that way". Most often this is a rationalisation covering up our own fear of being seen. It is more risky to be genuine that it is to put on a professional mask since if we have been genuine and we fail then we indeed have failed, but if we fail

in the role then it is not us who have failed it is therapy. The factors involved in the skill of being able to risk being genuine includes asking ourselves some pretty hard questions when we have found ourselves not being genuine, e.g. "why was I scared to be genuine?" "was I scared to be hurt". It also involves the on-going commitment not to get bogged down in habits based on a lack of genuineness.

7. Reduction in the need for validation by clients.

   Since a vital part of the person-centred approach to therapy is that the client gradually moves his locus of evaluation towards himself and increasingly and appropriately attributes his therapeutic movement to himself, it is important for the therapist to avoid seeking "strokes" from his client. This creates quite a paradox for the person-centred therapist: although he is struggling to create a therapeutic climate this may not be seen or valued by the client. Since most of us like to be rewarded when we are doing a good job it can be extremely difficult to cope with the relative absence of such rewards. Coping with this demands that the therapist himself have his locus of evaluation fairly firmly fixed within himself so that the intrinsic reward of feeling that he has done a good job can replace the need for such validation from the client. As well as this it often helps if the therapist has his own "reference group" from whom he can receive external support and validation.

It may be obvious from the above that these are very different kinds of "skills" from those which we normally associate with therapy. Most "skills" can be guaranteed to improve through practice, but the only one of the above for which this is generally true is empathy. As well as practice the others require a commitment to personal development not just during initial training, but throughout working life.

Training Development

Nether of these words really fits the process I am going to try to describe. "Training" carries the unfortunate connotative implication that we are talking about very definite things that can be taught by someone else. "Development" can carry the connotation that we are going to "develop" anyway whether or not we take a disciplined approach to it. Since I can't think of a better term than either of these, for the moment I'll stick to the term "training".

The main point to note about training in relation to the person-centred approach is that you can't tell anybody how to be person-centred. At least you can tell them, but it won't work.' My talk so far won't make anyone here any more person-centred - I could give ten lectures on empathy along, and it would not make anyone more empathic.

Skills like the examples above can only be developed through supervised experience. They are so personal - they involve the whole person so much that simply invoking the cognitive parts of a person can do little. Indeed psychological research into attitude development is quite clear on the relative impotence of informational elements: where information is inconsistent with the affective component of our attitude this information tends to be dismissed or distorted (I dare say there will be somebody here who finds some of the things I have said so inconsistent with their own feelings that they will have dismissed them out of hand or distorted them to fit their own meaning.

Feelings (the affective) are more powerful determinants of our attitude and consequent behaviour than thoughts (the cognitive).

Hence if we are going to develop person-centred attitudes through training we must reach the affective part of the trainee as well as the cognitive. Not only that, but we must centre the training process in the individuality of each student. By this I mean that we must approach the problem of, say, "defensiveness", from the starting point: "In what situations and in what ways does this particular student feel and respond defensively?" It is useless simply to present the student with a model of less-defensive therapist responses. Insofar as that student is more defensive than the model it's like showing a rabbit golfer a film of Severiano Balisteros thundering a 400 yard drive on the last green at St. Andrews and saying:"there - that's how it's done - now you try". On some of my teaching courses I show a video tape of myself working with a client - but only on those courses where the objective is simply to acquaint students with some of the variables involved in therapy. Where the aim is to actually develop the skills in the student, the showing of such a film is generally counter-productive, at least until they have got over the desire to model.

Taking these two central points of:

a. centring the training process in the individuality of the trainee ("individualised"), and

b. creating training which involves the affective as well as the cognitive ("experiential")?

what kinds of "activities" would be included in person-centred training?

1. Experiential groups: Students and tutors in small groups of ten to fifteen with no structure except the shared commitment to explore the ways they relate together. These "groups without a programme" bring in both the experiential and individualised aspects of the training right at the beginning. They serve to develop trust in the group as well as promote self-awareness and self-assessment. Such groups are likely to meet regularly throughout the course as well as continuously for the first few weeks of the course.
2. Role-play and analysis: A useful way into the therapeutic situation is to simulate it through role play. While this lacks the realness of actual therapy it gets as close as we can without involving clients at this early stage in training. Both the other students and the tutors are involved in helping the students to analyse what went on in the role playing.
3. Clinical experience: This involves actual work with clients - sessions are audio-taped and these tapes are analysed in the student/tutor group. (It is relevant to note here that it is very important that the tutors do not remain detached: they should be person-centred in this educational relationship in just the same ways as I have outlined for the therapeutic relationship.)
4. "Personal projects": The emphasis on the "individualised" aspect of training demands that students identify their individual weaknesses and strengths in relation to therapy. The student/tutor group will then try to help them to find ways of working on these weaknesses. This may include "stereotype bashing" and even projects aimed at extending the life experience of the student by, for instance, seeking experience in different work settings or investigation of different living conventions. (An example here is the student who had particularly strong views in support of the institution of marriage: this led him to be pretty intolerant of clients who brought the institution of marriage into question. The project which this student devised for himself was to spend three months living in a commune, where he hoped he would be brought face to face with his "block" on an every day basis.)
5. Cognitive input: This would include not only analysis of the theory underlying the person-centred approach, but also the theories underlying other approaches to therapy and familiarity with clinical terminology.
6. Training in other therapeutic disciplines (e.g. transactional analysis, Gestalt, behaviour therapy). The intention here is not to make the student into a Gestalt therapist, but to acquaint him with these other frameworks which might help him to gain perspective in his own thinking about therapy.
7. Self-assessment: The only logical end point of the initial part of a student's training in person-centred approaches is that he make his own assessment of his skills and his own "contract" for himself in the future. Here we are not talking about whether he gives himself A's, B's, C's etc., but a detailed analysis of how he sees himself in relation to therapy. This analysis would be presented to the support group of students and tutors who would then give him feedback in the same ways as they had done throughout the course. (It is not unknown for a student to conclude at the end of this lengthy first phase of training that he is not ready to enter therapy on a full-time basis).
8. Continued supervision and personal development: on a regular basis throughout working life. Here we are not necessarily talking about one supervisor: the therapist may find that different supervisors may provide different kinds of support.

It is obvious from the above that even on the initial training (steps 1 to 7) we are speaking more in terms of years than weeks or months.

One may say that in as much as person-centred therapy is focused on the person of the client, training for person-centred therapy is focused firmly on the person of the therapist.

Dave Mearns. Psychology Dept.,May, 1980. Jordanhill College of Education, Glasgow G13 1PP. Scotland.