

Person-Centred Rehabilitation Counselling: Revisiting the Legacy of Carl Rogers

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This article explores the relevance of Carl Rogers' person-centred approach (PCA) to rehabilitation counselling. His major theoretical contribution concerning the primacy of the client's actualising tendency and the six 'core conditions' of the counsellor–client relationship deserves greater recognition in vocational rehabilitation. The most widely known and researched core conditions have focused upon the proverbial triad: congruence (genuineness), unconditional positive regard and empathy. However, all six core conditions are discussed with emphasis placed on recent refinements to Rogers' original theory and their importance to rehabilitation counselling. Evidenced-based research concerning the impact of PCA-oriented rehabilitation counselling is lacking. It is argued that the efficacy of PCA can be extrapolated from meta-analyses in other fields of psychotherapy and education.

Keywords: person-centred counselling, Carl Rogers, rehabilitation

Carl Rogers has had a pervasive impact on the counselling profession. His theory and practice continues to be frequently cited in the counselling and psychotherapy literature (Goldfried, 2007) and applied by a wide range of helping professionals, regardless of their specific theoretical orientation (Cook, Biyanova, Elhal, & Schnurr, 2010; Richardson, Sheean, & Bambling, 2009). Historically, the boldness of Rogers' theoretical formulation (Rogers, 1957, 1959) has invited controversy, especially in regard to its opposition to medical, psychoanalytical and behavioural models of service delivery (Barrett-Lennard, 1998; Kirschenbaum, 2007). Critics have frequently argued that Rogers' 'nondirective' interpersonal style is necessary *but not* sufficient and should be complemented by therapeutic techniques (e.g., Goldfried, 2007; Watson, 2007). Likewise, rehabilitation counsellors may be inclined to adopt a nondirective interpersonal style that is a precondition, rather than a constant, for action-oriented services that involve problem-solving and skill development (See & Kramnetz, 2004). This article will, however, argue that it be applied throughout all phases of a rehabilitation program (cf., Mullins, Roessler, Schriner, Brown, & Bellini, 1997).

Rehabilitation counsellors may be discouraged from considering Rogers' perspective because, in its 'classical' client-centred form, it precludes strategies for acting on clients' problems in their social and physical environment. They may perceive it to be more relevant to process-oriented psychotherapies than rehabilitation counselling. However, Rogers' renamed *person-centred* approach (PCA) applies to goal-oriented

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programs and nonclinical settings in various spheres of life such as education, encounter groups, team building, employee relations and management (Barrett-Lennard, 1998; Kirschenbaum, 2007; Wood, 2008). Yet, these trends have been overlooked in recent critiques of Rogers' theory and practice (e.g., Mason, 2009).

It is also evident that contemporary PCA and *person-centred rehabilitation* hold similar but not identical theoretical assumptions. A recent critique of the latter by Leplege et al. (2007) acknowledged Rogers' influence but defined his contribution as narrowly 'individualistic' insofar as it 'puts the emphasis on the person as a whole' (p. 1564) and cannot be reconciled with other biomedical and social models of rehabilitation. Such critiques, however, neglect the development of Rogers' theory since his death in 1987 (Barrett-Lennard, 1998; Mearns & Cooper, 2005; Mearns & Thorne, 2007; Sanders, 2007). Calls for the development of a consistently applied model of person-centred rehabilitation (see, e.g., Gzil et al., 2007; Leplege et al., 2007) would be better served by acknowledging contemporary PCA literature. Present-day person-centred counsellors seek to empathically understand their clients' values and preferences for autonomy and interdependence in relationships with others at different points in their rehabilitation (cf., Cardol, De Jong, & Ward, 2002) and in other social systems (e.g., Barrett-Lennard, 1998; Schmid, 2001, 2002).

Rogers' client- cum person-centred approach has developed from a single, unified theory to one characterised by a diversity of experiential, existential and integrative approaches (Sanders, 2007). It is not the purpose of this article to discuss all these developments in detail. Instead, the aim of this article is to argue the relevance of specific aspects of PCA to rehabilitation counselling. Person-centred rehabilitation counselling will be discussed in terms of (a) comparative levels of intervention, (b) Rogers' core conditions of the therapeutic relationship and (c) the findings of evidence-based research. Comparisons will be made with other schools of counselling and psychotherapy; and, as often occurs in the literature, the terms counselling, psychotherapy and therapy will be used interchangeably.

Comparative Levels of Intervention

A continuum of different levels of 'interventiveness', delineated by Warner (2000), refers to the extent to which a counsellor 'brings in material from outside the client's frame of reference, and the degree to which this is done from a stance of authority or expertise' (p. 31). 'Classical' client-centred counsellors aspire to focus primarily on understanding the client's frame of reference. They avoid diagnosis, interpretation, technique, giving advice; and they cultivate a nonexpert role. Other PCA counsellors may provide resources, and offer ideas, interpretations and strategies in ways that encourage client choice. At the 'directive' end of Warner's continuum, PCA counsellors may employ strategies that are outside the client's frame of reference, or communicate in such a way that the client is unaware of the purpose of the counsellor's strategies. Person-centred *experiential* counsellors utilise interventions to deepen the client's emotional experiencing (Watson, 2007; Watson, Greenberg, & Lietaer, 2010). Warner observed that a counsellor's nonverbal gestures may reinforce or guide clients towards talking about certain topics. Communication techniques employed in *motivational interviewing* may selectively reinforce the client's change talk about their presenting problems (see Miller & Rollnick, 2002, pp. 102–109). There is a presumption of client resistance and of the effectiveness of the technique being undermined if the client becomes aware of the counsellor's intent. The intent here is not to dispute the efficacy

and collaborative 'spirit' of 'directive' therapies. Rather, the purpose is to distinguish the 'nondirective' and 'directive' elements of contemporary PCA.

Rehabilitation counsellors who work within a medical framework may 'pull together' with other rehabilitation professionals to provide vocational direction for their clients (i.e., 'pull factor' therapy; Dutta, Gerve, Chan, Chou, & Ditchman, 2008, p. 333). They may initially be nondirective, then 'increasingly ... provide services related to problem solving or skill development, consistent with behavioral and cognitive approaches' (See & Kramnetz, 2004, p. 90). An even more directive stance may be taken to manage client safety (e.g., avoid risk of injury) or promote compliance with mandatory guidelines. PCA counsellors may respond to these demands by adopting the dual roles of counsellor who respects the client's self-authority and consultant to other stakeholders (e.g., family, doctor, insurer) in the client's program (Finke & Teusch, 2007).

Rehabilitation counsellors who favour *cognitive-behavioural* strategies are likely to regard collaboration, the client's compliance with an agreed program and external regulation as key factors that enable clients to achieve their goals. Proponents of motivational interviewing usually equate successful therapeutic outcome with their own interpersonal (i.e., empathy) and technical (i.e., evoking 'change talk') skills. What distinguishes contemporary PCA from these and other therapeutic perspectives is the importance that person-centred counsellors attribute to the client's *actualising tendency*, the innate biological directional tendency to grow, develop and enhance self (Rogers, 1959). They trust in the client's actualising being the 'engine' of counselling (Bohart, 2007, p. 59). Research evidence reviewed by Bohart and Tallman (2010) supports the person-centred view that the counsellor relies upon the client's capacity for self-healing and self-righting to generate constructive change: clients are active agents and counsellors are support systems rather than expert guides or interventionists. From this perspective, clients may be inherently motivated to achieve their goals when they are afforded the core conditions of a therapeutic relationship, as discussed below; and when they are active co-managers in their vocational rehabilitation programs (Wright, 1983).

Overview of the Core Conditions of a Therapeutic Relationship

Relationship is at the centre of PCA. The counsellor promotes the client's actualising tendency by creating a therapeutic relationship that consists of six core conditions and that leads to therapeutic personality change (Rogers, 1957, 1959). The most widely known and researched core conditions focus upon the counsellor's attitudes of congruence (genuineness), unconditional positive regard (acceptance) and empathy towards the client. How rehabilitation counsellors may profitably utilise all six core conditions will be discussed. An overview of these six conditions is presented with emphasis placed on recent person-centred perspectives that have refined Rogers' original theory, and that are relevant to rehabilitation counselling.

1. *Psychological Contact*

Rogers (1957, 1959) conceived of *psychological contact* as a precondition for the therapeutic relationship; that is, as a minimal requirement that 'involves simply the awareness of both client and therapist' (Rogers, 1957, p. 96). Significantly, Rogers'

definition of contact has been elaborated and operationalised in relation to clients who experience difficulties in communication due to learning disabilities, psychosis, trauma or high levels of distress. Prouty (1976; Van Werde & Prouty, 2007) devised *pre-therapy* to be a practical, process- and reality-based method for forming therapeutic relationships with 'contact-impaired' clients. Pretherapy focuses upon concrete awareness: the counsellor makes contact with the client via reflections that are situational ('the room is cold'), facial ('you seem sad'), bodily ('your arms are folded'), word for word (repeating client's words to intensify feelings) and reiterative (when any of the above reflections yielded a response from the client). These reflections are meant to convey empathy and unconditional positive regard; to help the client make closer contact with his or her experiencing; and to reach the 'pre-expressive' self of the client and enable interaction (Van Werde & Prouty, 2007). Recent research findings suggest that pretherapy is highly effective and may be applied by a wide range of helpers in both clinical and nonclinical settings (Dekeyser, Prouty, & Elliott, 2008).

While emphasis has traditionally been placed on the work of the counsellor in reaching out to the client, contact evolves into a more dialogical encounter and is continually co-created and co-experienced by both counsellor and client (Wyatt, 2007). Psychological contact is likely to fluctuate depending on the momentary moods and behaviours of counsellor and client; and, for both counsellor and client, may also be mediated by the influences of ethnicity, class, religion and significant others such as family, special friendships, doctor, employer (Barrett-Lennard, 1998; Schmid, 2001).

2. Client Incongruence

Rogers (1957) defined incongruence as a 'discrepancy between the actual experience of the organism and the self picture of the individual's experience' (p. 222) that leads to the distortion or denial of organismic experiences and leaves the individual vulnerable to anxiety and depression. Organismic experience refers to the ways that persons experience themselves and their environment through their bodily felt sense (e.g., physical, sensory, visceral), cognitions and emotions. Rogers (1957, 1959) argued that these experiences were inhibited when persons 'introjected' the values or *conditions of worth* (i.e., adverse judgment, disapproval) of significant others to gain social acceptance.

Rehabilitation counsellors may encounter individuals whose *incongruence* can be attributed to being temporarily overwhelmed by traumatic onset of impairment, change of body image and the subsequent loss of valued social roles that are at odds with their self-concept. They may be assisted to explore the personal meaning of these experiences via the safety of a therapeutic relationship (discussed in more detail below). Other, deeply troubled clients may resist forming close relationships or alliances and be easily distressed by interpretation, advice or questions from counsellors. These persons, if diagnosed with a severe mood or personality disorder, need not be regarded as having a disorder or illness that precludes psychosocial rehabilitation. From Warner's (2007) person-centred perspective, psychopathology can be reconceptualised as *difficult* or *fragile process* that refers to those persons who have difficulty in holding their own experiences in attention and who cannot take in the views of others without feeling violated or threatened. It is recommended that counsellors stay very close to the client's actual words, be highly sensitive to the quality of interaction, refrain from asking the client to reflect on his or her experiences and avoid making empathic responses to feelings that are outside the client's awareness. Contrary to

many other therapies, PCA counsellors are likely to take the view that 'human beings have exceedingly strong inclinations and capacities to process experience, however much they have suffered life challenges' (Warner, 2007, p. 164).

3. *Congruence*

Congruence (genuineness) refers to the consistency or matching between a counsellor's inner experiencing and their outward responses to the client. Counsellors may, for example, experience feelings related to the quality of the counsellor–client relationship. They need not express or talk out all of their feelings, but ensure that they do not dissemble or deceive their clients about themselves. The counsellor's aim is to express genuinely felt responses to the client's experiencing in the immediate moment; and for the client to perceive the counsellor's responses as genuine, transparent and honest.

Congruent counsellors work to diminish any illusions their clients may have of their power and authority: they do not claim to know more about the client's experiencing than the client, they are open about their personal limitations and mistakes in empathic understanding, they are prepared to learn and appreciate the diverse cultural contexts in which their clients live (Cornelius-White, 2007a; Mearns & Thorne, 2007; Schmid, 2001). They seek to understand their clients' configured social identities rather than reduce them to their visible, 'presentational' or 'disability' identities (cf., Wright, 1983). They are prepared to explore their own attitudes, prejudices or stereotypes about disabled groups who seem to be 'different'; to learn how their clients perceive them in relation to personal and/or role power; to take an idiographic approach and modify their skills and language in relation to the diverse characteristics of their clients (Lago, 2007).

4. *Unconditional Positive Regard*

Unconditional positive regard (UPR) refers to prizing the client's experiencing in a nonjudgmental way that is free of the *conditions of worth* that the client may have introjected from society and significant others. But, as observed by Barrett-Lennard (1998, p. 100): 'To be unconditionally responsive to the experiencing person does not mean accepting all their behaviour ... It is not the other's actions but their self or personhood that I ... prize'. UPR is offered as a model of nonjudgmental self-acceptance for clients together with an 'understanding-seeking approach' to working with clients from 'different' and 'diverse' backgrounds (Lago, 2007, pp. 262–263).

The concept of UPR has been contextualised as part of a process that entails mutual acknowledgment, a co-receiving of experiences and perceptions (Bozarth, 2007). Both counsellor and client may receive positive regard and experience themselves as making a positive difference in the experiential field of the other. Within institutional-centred policies or legislative mandates, they both give and receive information and play an active part in decision-making; that is, they actively participate as co-managers in the planning, implementation and evaluation of their programs (cf., Wright, 1983, p. 438).

5. *Empathy*

The therapeutic value of *empathy* is acknowledged by most counsellors, regardless of their theoretical orientation (Cook et al., 2010; Richardson et al., 2009). However, from Rogers' (1957, 1959) perspective, empathy is an attitude rather than a set of

reflective techniques instrumental for achieving goals. The client is afforded a climate of acceptance and safety in which to explore painful or difficult experiences that have not been admitted into his or her self-concept. Empathy communicates the counsellor's unconditional positive regard and conveys to clients that they are deeply heard (Bozarth, 2007). It facilitates self-agency by being offered as a form of enquiry that may be corrected by the client, and by asking clients to reflect on their experiencing and to reach their own judgments about the process (Barrett-Lennard, 1998; Mearns & Thorne, 2007).

Receiving the counsellor's empathy enhances the client's capacity to empathise with others; it raises their awareness of the dialectic inherent in finding a balance between self-agency *and* their interdependence with the counsellor and significant others (e.g., family, friends, doctor, insurer, current or prospective employer) who may impact upon their rehabilitation. While person-centred counsellors take the role of companion at the client's side, co-experiencing the client's concerns, they may 'extend beyond empathic awareness in the range we are most familiar with ... [i.e.] not only 'taking in' the client in their separateness and singularity but in their connectedness and engagements in their world' (Barrett-Lennard, 1998, pp. 340–1). They reflect back to the client the multiple, contradictory ways in which they experience their social world. It is recommended that PCA counsellors neither avoid confrontation, nor simply apply reflective techniques; and that they appreciate the client who 'stands counter' to them and allow themselves to be 'touched by the essence of the opposite' (Schmid, 2002, p. 60). They may also communicate how much they have been affected by their encounter and thus provide a vivid sense of their empathic understanding for the client while not ignoring their differences (see, e.g., Mearns & Cooper, 2005).

6. Client's Perception

The efficacy of PCA rests on the client perceiving the counsellor's UPR communicated through empathic understanding of the client's internal frame of reference. Research findings indicate that clients' perceptions of counsellors' empathy and UPR are stronger predictors of therapeutic outcome than the ratings of counsellors and observers (Lambert & Barley, 2001). A similar trend was evident in a recent meta-analysis of learner-centred teacher–student relationships (Cornelius-White, 2007b). The qualities of nontherapeutic relationships in a variety of contexts broadly correspond to the core conditions of counselling defined by Rogers (Barrett-Lennard, 1998; Kirschenbaum, 2007). These findings suggest that rehabilitation counsellors may apply PCA regardless of whether they perceive their work as therapeutic or nontherapeutic, process- or outcome-driven. Not all rehabilitation clients seek or need counselling, and those who do may prefer 'directive' counsellors who impart strategies to solve problems or achieve goals instead of focusing on their experiences in interpersonal relationships. Nevertheless, they are likely to value rehabilitation counsellors who are available, *congruent* (without pretence or façade), accepting, nonjudgmental and who show empathy for their points of view.

Evidence-Based Research

Evidenced-based rehabilitation research has produced equivocal findings concerning the impact of counselling. In a major study conducted in one US state by Bolton,

Bellini and Brookings (2000), vocational rehabilitation counselling was excluded as a predictor of vocational outcome. Bolton et al. argued that since there was 'little variability for these services, there was little potential for predicting any type of vocational outcome' (p. 14). However, in another major study with a large national US sample, Pack and Szirony (2009) reported that receipt of vocational rehabilitation counselling was associated with vocational outcome. Contrary to the trend observed by Bolton et al., only 54% of Pack and Szirony's sample received vocational rehabilitation counselling and guidance, which suggests that too few clients received counselling. On the other hand, rehabilitation counsellors and/or clients may have perceived that counselling was not required, or placed less importance on counselling than on job placement services. Rehabilitation counsellors are perhaps divided on this issue (Pack & Szirony, 2009) and the extent to which they integrate practical vocational services with counselling for personal adjustment and psychosocial issues (Dutta et al., 2008; Mullins et al., 1997).

Evidenced-based rehabilitation research has not discriminated PCA from other types of counselling. The efficacy of person-centred rehabilitation counselling can be extrapolated from meta-analyses in other fields of, for example, psychotherapy and education. Elliott and Friere (2010) included 186 studies involving more than 14,000 clients. Person-centred and experiential psychotherapies (PCE) were found to be clinically and statistically equivalent to other therapies in 91 randomised clinical trials (RCTs). They also reported small effect sizes that indicated PCE was trivially worse than cognitive-behavioural therapy (CBT) in 63 RCTs. This result was, however, attributed to researcher allegiance by Elliott and Friere who are themselves aligned to PCE. Subsequently, so-called supportive therapies, inexactly labelled by CBT-oriented researchers as 'supportive' or 'nondirective' were removed from their analyses. It was then found that *bona fide* PCE was statistically equivalent in effectiveness to CBT in 18 RCTs. A similar result was reported by Stiles, Barkham, Mellor-Clark and Connell (2008), researchers with different allegiances, in a large ($N = 5613$) nonrandomised study of persons treated in primary care mental health services in the United Kingdom. These findings confirm *common factors* research that indicates that counsellors with different theories and techniques tended to have similar outcomes for clients with a similar range of disorders. The findings suggest that therapeutic outcome is more likely to be determined by the client's personal resources and the quality of the client-counsellor relationship than by the counsellor's technical expertise (Lambert & Barley, 2001). But, since there were significant differences within the therapeutic groups, outcome was also likely to have been determined by how effectively counsellors delivered services and responded to the different needs of their clients (see, e.g., review of evidence-based research for PCE therapies; Watson et al., 2010).

Evidence-based research studies have measured outcome primarily in terms of symptom reduction (see, e.g., Gibbard & Hanley, 2008; Stiles et al., 2008; Zuroff & Blatt, 2006). On the other hand, qualitative researchers have found that clients reported other important outcome indicators such as greater appreciation of vulnerability and emotional pain, as opposed to symptom relief; greater sense of empowerment and self-compassion; better understanding of self and others (Timulak & Creaner, 2010). While these outcomes are of interest to rehabilitation counsellors, they are more likely to be held accountable for their clients' achievements in obtaining and maintaining employment. Evidence from educational research suggests that person-centred rehabilitation counsellors could make an important contribution

to programs that require the achievement of specific outcomes. The meta-analysis of 119 studies with 355,325 students by Cornelius-White (2007b) found that most student-centred teacher variables (i.e., nondirectivity, empathy, warmth, encouragement of higher order thinking) had above-average associations with cognitive student outcomes, notably critical/creative thinking, math and verbal achievement. Student-centred education was also associated with large increases in participation, satisfaction, motivation to learn; and in reduction in drop-out, disruptive behaviour and absences. The results of this meta-analysis invite caution insofar as most of the studies were correlational, and did not tap into the likely reciprocal effects of teacher and student behaviour; relatively few studies (33%) were RCTs; and *congruence* of the educator was not significantly related to student outcomes, perhaps because it is harder to measure. Nevertheless, learner-centred teacher variables similar to those valued by most rehabilitation counsellors were associated with student achievement.

Conclusions

Rogers' PCA, in its refined contemporary form, is relevant to the various tasks of rehabilitation counselling. Person-centred rehabilitation counselling was discussed in terms of (a) comparative levels of interventions, (b) Rogers' six core conditions of the therapeutic relationship and (c) the findings of evidence-based research. Consistent with the classic work of Wright (1983), PCA promotes clients as co-managers in the planning, implementation and evaluation of their rehabilitation program. The client's capacity for self-healing and self-righting generates constructive change: clients are active agents and counsellors often act as support systems rather than expert guides or interventionists. While evidence-based rehabilitation research has not always identified the counsellor–client relationship as a key variable, PCA has received strong support from evidence-based research in other fields of counselling and education. It is recommended that rehabilitation counsellors apply, and researchers evaluate, PCA in rehabilitation service delivery.

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