

A Comparative analysis of Person Centred Therapy and Choice Theory / Reality Therapy

Introduction

An enormous variety of counselling approaches have been developed since the popularisation of ‘talking therapies’ by Freudian psychoanalysts in the late 19th and early 20th Century. While many contemporary psychotherapists practice an eclectic or integrative helping style (Corey, 2008), at least 240 distinct theoretical approaches are in widespread application (Cheston, 2000). Two such paradigms are Client Centred / Person Centred Counselling (PCC), developed by Carl Rogers from the 1940s on (Rogers, 1947), and Choice Theory / Reality Therapy (CT / RT), created by William Glasser (Glasser, 1998) in the 1950’s and elaborated by Robert Wubbolding (Wubbolding, 1988). Both therapies have been applied across diverse contexts, from individual counselling to group work (Barrett-Lennard, 1998) and educational environments (Glasser, 1998), and together serve to illustrate two examples of the alternative constructions of the individual, and the causes and treatment of mental disorder that have developed through psychotherapeutic practice.

This essay will introduce some of the history of, and concepts at work in CT / RT and in PCC, and analyse these methodologies through the Ways Paradigm developed by Sharon Cheston (Cheston, 2000). The Ways Paradigm catalogues the significant differences between counselling approaches by comparing their application as a way of *being* in the interpersonal dynamic, their theoretical *understanding* of psychopathology and mental functioning, and their techniques of *intervening* in the counselling relationship.

The essay will go on to compare and contrast CT / RT and PCC, and assess the strengths, weaknesses and multicultural applications of each model.

Introduction to Person / Client Centred Therapy

Client Centred Therapy has its roots in psychoanalytic thought, Freud's belief in change through catharsis and insight, and the post-Freudian emphasis on the individual organisation of experience (Rogers, 1947). However, the PCC approach was amongst the first to abandon psychodynamic efforts to riddle out the unconscious conflicts and developmental dysfunction underlying mental illness. For person centred therapists, the relationship between client and counsellor – rather than the theoretical or methodological approach of the practitioner – determines the success or failure of psychotherapy. Person centred therapeutic approaches are widely used in the treatment of anxiety, substance abuse, depression, personality disorders etc (Corey, 2008). As an exemplar of the warm, non-directive therapeutic relationship, the person centred approach has influenced the practice of many therapists outside its theoretical emphasis (for example in Relational Gestalt Therapy) (Corey, 2008).

Another influence of PCC within contemporary psychotherapy springs from Rogers' efforts to apply scientific measurement to counselling. Rogers' practice of releasing recordings and transcripts of client therapist interaction, and his de-medicalisation and demystification of the therapeutic process; continue today in the efforts of clinical psychologists to root treatment programmes in evidence based technique (Barker et al, 2002).

Carl Rogers Biography

Carl Roger's career spanned much of the twentieth century, and its impact on counselling, group therapy and conflict resolution was considerable (Kirschenbaum, 2007). Rogers was raised by strict, conservative Christians in the American Midwest. The family were so emotionally repressive and controlling that Rogers and two of his siblings developed ulcers in adolescence (Cohen, 1997). Academically gifted though socially isolated, his childhood interest in entomology developed into a fascination with scientific agriculture which informed his later psychological research. Rogers studied agriculture, history, Christian ministry and finally psychology. Student experiences with group discussion and travel to China broadened his appreciation for diverse viewpoints. Rogers developed a popular personality test for children, and went on to work in child counselling and research. At the Rochester Society For The Prevention Of Cruelty To Children, Rogers developed his client driven approach, and emphasis on the non-judgemental therapeutic relationship (Thorne, 2006). As a professor at Ohio State University he critiqued more directive therapies, and emphasised the importance of emotion and growth in the therapeutic encounter, reconceptualising the patient as a 'client'. Rogers established a democratically organised counselling centre at the University of Chicago, publishing books that crystallised PCC and carrying out research in to the efficacy of psychotherapy. In 1961 with the publication of *On Becoming a Person*, Rogers' theories gained public influence, which he used to promote 'encounter groups', alternative educational approaches, and later to broaden the application of his ideas to politics and society. Towards the end of his life Rogers gained a renewed interest in spirituality and travelled globally to facilitate and teach conflict resolution (Thorne, 2006).

Rogers originated the term counselling in order to avoid conflicts with the American psychiatric establishment over the treatment of psychological distress by unlicensed practitioners (Thorne, 2006).

Rogers has been criticised for a variety of aspects of his personal and professional life, including his involvement in covert CIA research from the late 1950's on (Kirschenbaum, 2007) and his alcoholism and infidelity to his invalided wife in the 1970s (Cohen, 1997).

Person Centred Counselling as a Way of Understanding

PCC is a humanist perspective that presents an essentially positive view of human nature (Kirschenbaum, 2007). Rogers believed in the growth directed, actualising tendency of 'whole organism' (Thorne, 2006). For the person centred counsellor the counselling process relies on the internal resources of the client – self actualising 'constructive forces' (Rogers, 1951) that incline the individual towards personal development.

PCC takes its concept of the 'self construct' from Fritz Perls' Gestalt approach (Rogers, 1961). For Rogers the self is a fluid reflexive response to the person's environment and relationships (Thorne, 2006). Psychological defences are activated by a dissonance between the perceived and desired self; and the client's quest in the therapeutic process is for authenticity and self knowledge (Rogers, 1961).

Rogers believed that parent conditions on the positive regard they provided to their developing children lead to conflicts between a child's actualising motivational system and their need for positive regard. This created an external locus of evaluation that damaged self worth and led to psychological problems.

To Rogers therapy was a learning process. One in which the client moved toward an internal locus of control and more mature behaviours that accorded with the reality principle, responsibility and openness to experience (Thorne, 2006).

Person Centred Counselling as a Way of Being

PCC emphasises three core conditions: Empathy (understanding another's subjectivity), congruence (genuineness and authenticity to moment by moment experience) and unconditional positive regard (warmly accepting all aspects of the client's personality, however uncomfortable). Person Centred Therapists avoid diagnosis and advice, deferring to what Rogers' described as the 'creative and integrative insight of the organism' (Rogers, 1946).

Person Centred Counselling as a Way of Intervening

While the explicit interventions in PCC are minimal, Rogers does outline a variety of 'necessary conditions' for therapeutic helping. These are a series of assumptions and behaviours by the therapist that facilitate change, including: client's responsibility for self, a warm / permissive atmosphere, and a safe space to express uncomfortable feelings, non-judgemental understanding (Rogers, 1946). The person centred therapist avoids evaluation, interpretation and advice; and strives to accept client's negative and positive attitudinal expressions equally.

Roger's believed that when core conditions successfully facilitated a helping relationship, the client proceeded from catharsis to insight and finally to positive choices and actions (Rogers, 1951).

Introduction to Choice Theory / Reality Therapy

Choice theory (Glasser, 1998) is not simply a cognitive behavioural approach to counselling, focusing on the development of self efficacy and volition through practical behavioural interventions. It is also a philosophical framework tying together physiological, affective and cognitive function as well as action, under the rubric of total behaviour.

In its current flavour CT emphasises the impossibility of controlling another person (Glasser, 1998), and has de-emphasised RT's initial focus on responsibility and worthwhileness (Glasser, 1975).

William Glasser Biography

Dr William Glasser initially developed Reality Therapy in the early 1960's as an intervention for dealing with the mentally ill and young offenders in institutional contexts (Glasser, 1975).

Control Theory (later renamed Choice Theory) was developed by Glasser as a theoretical framework for understanding the person, underlying the interventions of Reality Therapy (Glasser, 1989).

CT was formulated against the backdrop of mid 20th century behaviorism's total rejection of human agency, and fixation on the possibility of controlling behaviour (Rogers, 1990). The theory represents an alternative construal of the person as an intentional actor who cannot be directly controlled, rather than as a set of stimulus responses or socially learned scripts and roles (Glasser, 1998).

William Glasser has gone on to apply choice theory to schooling, both as an intervention for troubled schools and a methodology for the development of new 'Quality Schools' where non-compulsion, quality work and problem based learning are emphasised, and testing, discipline and streaming avoided (Glasser, 1998).

Glasser's ideas about relationships and non-compulsive collaboration have been applied to the world of business via his Lead Management approach. The William Glasser Institute in California, established in 1967 continues to promote and develop his research and the practice and training of CT / RT, Quality Schools and Lead Management (Glasser, 1998).

Choice Theory as a Way of Understanding

Choice theory posits that our actions and thoughts are directly chosen, and through them we can indirectly modify our feelings, physiological functioning and disease processes (Glasser, 1998). Reality Therapy (Glasser, 1975) attempts to treat unhappiness and psychological disorder through teaching clients to meet fundamental needs for survival, love and belonging, fun, power and freedom (Glasser, 1998). Needs that can only be met through relationships with happy sociable people (Glasser, 1998). For Glasser, need strength profiles underlie personality differences, and their complementarity is an important determinant of relationship success (Glasser, 1998). Need fulfilling fantasies and past experiences are stored in a 'mental picture album' motivating purposive efforts to reduce the gap between perceived and desired worlds (Wubbolding, 1998).

Reality Therapy as a Way of Being

In the therapeutic context, RT is both confrontational and empowering, since it emphasises the individual's responsibility for, and capacity to change; and disputes client 'excuses' (Glasser, 1975). CT's emphasis on current relationships means past experiences are deemphasised, and interventions can be brief and solution focused. The reality therapist provides a supportive, non-critical, challenging environment, encouraging the client's realisation that change is possible but requires their active involvement. The reality therapist aims to maintain a positive, non-judgemental, enthusiastic frame, using humour, warmth and counselling microskills (Glasser, 1975) to convey care for and interest in their client (Corey, 2008).

Reality Therapy as a Way of Intervening

The WDEP procedure developed by Robert Wubbolding formalises the RT approach to intervening. WDEP involves the counsellor

guiding a client through an evaluation of a) the clients 'wants' and needs, b) the 'direction' of their life and an examination of their 'doing' behaviour, c) an evaluation of the efficacy of their *total behaviour* and d) the formulation of 'plans' by the client and therapist in collaboration (Corey, 2008). This approach can be taken to an individual issue or relationship, and is non-prescriptive in its order and specifics.

Wubbolding also suggests the use of a series paradoxical techniques to dissolve client resistance and escape client excuses (Wubbolding, 1988). Paradoxical techniques involving behaving or recommending a behaviour that runs counter to client expectations or actively encourages a client to reinforce unhealthful thinking or behaving (in order to place that behaviour under their control) (Wubbolding, 1988).

Comparative Analysis

Choice theory / Reality Therapy and Person Centred Therapy share a lack of interest in dreams, client's past traumas, the content of the unconscious and the need for the therapist to understand the particular roots of dysfunction. Both are talking therapies, which endeavour to ultimately increase the client's agency and facilitate behavioural change; rather than focus on the pharmacological amelioration of symptomatology. Both approaches avoid the syndromal classification of psychological disorder typified by the Diagnostical and Statistical Manual of Mental Illness (APA, 1994), in favour of conceptualising the client as a whole person whose symptoms are efforts to successfully navigate their lived experience.

Both therapies suggest an innate human capacity for and tendency toward growth in stark contrast to Freud's view of human nature as 'wild, unsocialised, selfish and destructive' (Kirschenbaum, 2007)

Finally both approaches attempt to return to the client a perception of control over their own lives and behaviour.

While many of the underlying assumptions of CT / RT and PCC seem congruent, the behaviour of the therapist in the counselling environment can be radically different. While the Person Centred Therapist tries to dissolve resistance by avoiding evaluation and advice, relying on the client's innate capacity for personal development to facilitate change; the Reality Therapist actively encourages the client to evaluate their own behaviour, and may offer advice or suggest specific plans for behavioural change. The 'demand characteristics' of the client (Kanter et al, 2002) in PCC are of a gradually more emotionally connected, present focused, self actualiser; while in RT the client is encouraged to become adept at reframing, planning and evaluation.

Strengths & limitations of each model

The great strength of Choice Theory / Reality Therapy is its emphasis on rapid behavioural change and the improvement of relationships. The faith of psychoanalytically derived therapies in the power of insight to resolve psychological conflict (Dilman, 1988) ignores the very real situational components of many psychological problems. By focusing only on that element of the client's world that they can change (their behaviour), RT quickly provides clients with the pragmatic advice that counselling efficacy research shows they seek (Elliot & Williams, 2003).

Although the evidence based aspirations of PCC may have been initially limited by simplistic statistical tools and inadequate methodological rigour (Kirschenbaum, 2007); PCCs attempt to

scientifically evaluate the efficacy of psychotherapy prefigured today's research based therapeutic approaches (Barker, & Pistrang, 2002). By contrast, a significant weakness of Choice Theory is Glasser's tendency to substitute aphorisms for references and research. One vivid example is his presentation of a graph of human technical progress as compared to human progress since 1900 (Glasser, 1998), which seems entirely arbitrary, ignoring the changes in human and civil rights over the period; for example decolonization, suffrage for women and African Americans, gay rights, the legalisation of contraception and the acknowledgement of the criminal status of rape within a marriage.

Another weakness is Glasser's assertion that external control psychology is responsible for all social problems (Glasser, 1998); ignoring the complex multi-factorial components of such diverse issues as the construction of criminality and social changes in attitudes towards sexual promiscuity (Giddens, 2009).

In advocating CT as a methodology to prevent social problems (Glasser 1998), Glasser seems to make the logical mistake of confusing the efficacy of an intervention with the underlying causation of a problem, like a doctor deducing that a shortage of antibiotics is the cause of a bacterial infection.

Glasser's four non-survival needs represent an attempt to create a theory of personality and motivation ignorant of psychological research into dimensional personality traits, for example the situational trait approach (Allen & Smith, 1980); and Glasser provides no research evidence for their pre-eminence over other well defined and researched needs (e.g.: sexual intercourse, creativity, social dominance). Glasser's concept of a creative system responsible both for the development of psychosomatic illness and problem solving, departs radically from contemporary psychological and neuroscientific

research into thinking, judgement and decision making (Kahnman & Tversky, 2000). Choice Theory does not offer a ‘new psychology’ so much as an alternative clinical philosophy. Glasser’s approach contains many fascinating ideas – for example his postulation that depression is a chosen behaviour that helps clients resist change, repress anger or elicit attention (Glasser, 1998). But in the absence of research confirming such a hypothesis, its application in the clinical setting could be irresponsible.

The assertion that all behaviour is chosen is deeply problematic too. Self directed behaviour occurs within a matrix of social learning, conditioning and available opportunities that delimit choice. Many disease processes (physical and neurological) curtail choice, as do social, wealth, racial and gender inequalities (Marmot, 1999).

On the other hand – by placing the responsibility and possibility for change in the hands of the client, Choice Theory can be understood from a social constructivist perspective as an empowering ideology (Jefferson & Harkins, 2011) that takes the control and understanding of mental illness out of the exclusive domain of medicine and psycho-pharmaceutical intervention.

Glasser’s opposition to disciplinarian schooling (Glasser, 1998) accords with many significant critiques of the failing western educational paradigm (Meighan, 1995).

PCC is not problem focused, and its reliance on catharsis and the innate tendency towards self actualisation may make it inappropriate for compulsive and depressive problems. By allowing the client to direct the course of discussion, and practicing unconditional positive regard, the person centred counsellor could potentially collude in ignoring problematic behaviours and irrational beliefs, and neglect unexpressed (perhaps unconscious) problems underlying dysfunction.

In the contemporary clinical setting, where the availability of psychopharmacological interventions and health insurance emphasise brevity, the lengthy process of traditional client centred therapy may often be impossible.

Applications of each model in a multicultural setting

The empathy and value neutrality of the person centred ‘way of being’ make it ideal for use in a multicultural context (Corey, 2008).

However PCC’s emphasis on client talk may run into difficulties with clients who don’t share the same native language as their counsellor. Natalie Rogers’ Person Centred Expressive Art Therapy, and other non-verbal person centred approaches may be more appropriate for culturally diverse and non-verbally orientated clients (Corey, 2008).

The emphasis on readily understandable needs, wants and behavioural plans by CT / RT may make it more broadly accessible cross culturally. However RT’s individualist focus and de-emphasis of group dynamics, such as family role and religious observance could potentially create conflicts with clients from collectivist cultures. Glasser’s criticism of the ‘workless’, whom he likens to sociopaths and suggests should be institutionalised (Glasser, 1998) limits Choice’s theories applicability outside Western capitalist systems of individuated personal responsibility; or with clients who don’t share Glasser’s love for “our economic system” (Glasser, 1998, pp 273).

Choice theory suffers from a blindness to situational inequalities (physiological problems, varying intellectual resources, risk and resilience factors etc).

Evaluation

Strengths & limitations, critical analysis

PCC can be criticised for its absence of directivity. Watching Roger's perform therapy, his avoidance of advice is striking (Moon, 2011). While this serves to reduce resistance, it does not necessarily accord with what clients find helpful (Elliot & Williams, 2003).

CT / RT's avoidance of past trauma may make it unpalatable for clients who feel the desire and seek in counselling the platform to catharsise incidents of childhood abuse. In such circumstances the assertion that 'present relationships are always the problem' (Glasser, 1998), seems disingenuous and reductive. Relationship dysfunction may spring from underlying neurological disorder, personality disorder (APA, 1994) or addiction (Bradshaw, 1988): suggesting that in some cases relationships or their lack may be a symptom of, rather than the problem underlying, client distress.

Implicit in Reality Therapy is the concept of mental illness as 'denial of reality'. Historically mental health services have often been used to suppress dissent (for example within Soviet Psychiatry) – and a disagreement about the aspects of our socially constructed reality underlies all social development (e.g.: the emergence of feminist consciousness and the women's rights movement). As George Bernard Shaw said "The reasonable man adapts himself to the world; the unreasonable man persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man." Social deviance is not by itself 'irrational', and CT's critique of psychoanalytic opposition to "conventional morality" (Glasser, 1975) ignores the highly repressive and patriarchal nature of late 19th and early 20th century social and sexual relationships.

Conclusion

CT / RT and PCC are approaches to the treatment of mental illness in radical opposition to the rigid categorisation of mental illness, epitomised by the widely disputed (Whitaker, 2011) categories of the DSM IV-TR (APA, 1994). In an era of commercialised bio-medical treatment of mental illness, both approaches offer a humane alternative. While they disagree in their conception of the person and their methodologies for intervention, both paradigms provide a positive, hopeful engagement in which therapeutic change can occur. In the contemporary integrative context, the core conditions of a person centred way of being may offer a useful relational style for the Reality Therapist. While the plan making, future focused positivity of Reality Therapy could offer a useful addition to the skill set of Person Centred Therapists, especially with clients who seek concrete changes in their lives, or whose time in therapy must be brief.

References

- Allen. B. P., Smith, G. F., (1980). Traits, Situations, and their interaction as alternative ‘causes’ of behaviour. *Journal of Social Psychology*, 111, 1, 99-105
- American Psychiatric Association (1994) *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders (Diagnostic & Statistical Manual of Mental Disorders)*. USA: American Psychiatric Press.
- Barker, C., Pistrang, N., Elliot, R. (2002) *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners, 2nd Edition*. UK: John Wiley & Sons.

Barrett-Lennard, G.T. (1998) *Carl Roger's Helping System, Journey and Substance*. London: Sage.

Bradshaw, J. (1988) *Healing the Shame that Binds You*. USA: Health Communications Ltds.

Cheston, S.E. (2000) A New Paradigm for Teaching Counseling Theory and Practice. In: *Counselor Education and Supervision*. Vol: 39. 4. PP

Cohen, D. (1997) *Carl Rogers A Critical Biography*. Great Britain: Constable.

Corey (2008) *Theory & Practice of Psychotherapy*. UK: Wadsworth

Dilman (1988) *Freud, Insight and Change*. UK: Blackwell.

Elliot, M. & Williams, D. (2003) The Client Experience of Counselling and Psychotherapy. *Counselling Psychology Review*. Vol 18, No:1.

Giddens, A. (2009) *Sociology*. UK: Polity Press.

Glasser, N. (Ed) in Glasser N. (1989) *Control In The Practice of Reality Therapy*. USA: Harper & Row.

Glasser, W. (1975) *Reality Therapy*. USA: Harper & Row.

Glasser, W. (1998) *Choice Theory*. USA: Harper Collins.

Jefferson, D.J., Harkins, D.A. (2011) "Hey, I've Got a Voice Too!" Narratives of Adversity, Growth and Empowerment. *Journal for Social Action in Counseling and Psychology*. Vol 3. No 2.

Kahneman, D., Tversky, A. (2000) *Choices, Values and Frames*. UK: Cambridge University Press.

- Kanter, J.W., Kohlenber, R.J., Loftus, E. (2002) *Demand Characteristics, Treatment Rationales, and Cognitive Therapy for Depression*. Prevention & Treatment, Vol 5, 41.
- Kirschenbaum, H. (2007) The Life And Work Of Carl Rogers. Great Britain: PCCS Books.
- Marmot, Michael (1999) *The Social Determinants of Health Inequalities, From: Health/Nutrition/Population (HNP) and Poverty Seminar Report*, Hosted: World Bank [Web]. Time: 29/11/02, 14.20. Available at:
<http://www.worldbank.org/poverty/health/library/nov99seminar.pdf>
[Accessed 11 January 2012]
- Meighan, R. (1995) *John Holt: Personalised Education & The Reconstruction of Schooling*. USA: Educational Heretics Press
- Moon, K.A. (2011) *A Client-Centered Review of Rogers With Gloria*. *Journal of Counseling & Development*. Vol 85, 3, 277-285.
- Rogers, C. (1947) *Counselling & Psychotherapy*. USA: Houghton Mifflin Company.
- Rogers, C. (1951) *Client Centred Therapy: It's Current Practice, Implications and Theory*. United Kingdom: Constable.
- Rogers, C. (1961) *On Becoming a Person*. Great Britain: Constable.
- Rogers, C. (1990) *Carl Rogers Dialogues*. UK: Constable and Robinson.
- Thorne, B. (2006) *Carl Rogers*. London: Sage Publications.
- Whittaker, R. (2011) *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in*

America. USA: Broadway Books.

Wubbolding, R.E. (1988) *Using Reality Therapy*. USA: Harper Perennial.