Person-Centered Counselors in Community Prevention and Research

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Abstract

The core tenets of a person-centered counseling perspective are similar to the guiding principles of a complementary approach to research. The Community-Based Participatory Research model (CBPR) is outlined to provide counselors with an approach to research that will resonate with a person-centered theoretical framework. In order to improve health outcomes, Minkler and Wallerstein (2008) contended CBPR equitably draws upon the strengths of community members, organizational representatives, and researchers through a collaborative approach. Counselors, working from a community perspective identifying with a person-centered orientation, may find a new avenue to address prevention and research. Specifically, for counselors working in communities where prevention and research are aimed at reducing health disparities, counselors can work within a CBPR framework to form equitable and sustainable partnerships that complement the person-centered counseling perspective.

Keywords: Community-Based Participatory Research (CBPR), Humanism, Person-Centered Counseling

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Carl Rogers (1957) developed the person-centered approach to therapy to elucidate the importance of the therapeutic relationship as a means for individual growth. In person-centered counseling, the practitioner urges the creative capacity of the individual to actualize one's purpose through mechanisms, such as, free will and personal acceptance, as sufficient for their development (Buhler, 1971; Hansen, 2006). Likewise, in the practice of Community-Based Participatory Research (CBPR), a researcher cannot act in isolation from community for the change to be beneficial, long lasting, and effective (Minkler & Wallerstein, 2008). CBPR is a collaborative approach to research that involves the equitable partnership of researchers and community members building on the unique assets that each member brings to the process (Minkler & Wallerstein, 2008).

In the CBPR collaboration, where both researcher and community contribute equally to co-learning process, participants can increase control over their lives and ultimately develop a sense of empowerment (Minkler & Wallerstein, 2008). Minkler and Wallerstein (2008) proposed that CBPR can be best defined as community-based rather than community placed. The community and the researcher that facilitate the process direct the form of inquiry. For instance, asking the questions upfront to assess what and how the community would like to target to improve their health and ideally their quality of life. By asking these questions in the beginning, the long-term survival of the program may be enriched. Ultimately, CBPR achieves a balance between research and action.

An expression of the type of research endorsable by the person-centered perspective might be the CBPR approach. As a person-centered counselor, one acts as a catalyst to assist the client in developing a healthier way of being according to his or her own personal values and or cultural belief set. Their meaning sets the stage for the therapeutic process to occur in accordance with the

actualizing tendency (Rogers, 1957). The *actualizing tendency* is the inclination for all organisms to shift in the direction towards change versus stagnation even when the progression is distressing (Rogers, 1951). Person-centered counselors must retain this core philosophy when working with their clients to trust their client's innate capacity to manage all aspects of their life (Rogers, 1951). By engaging in the relationship, the therapist is promoting long- term changes within the individual that meet their own personal expectations for change. The CBPR approach addresses individual and community level needs from the beginning of the process by assigning each member of the community, including those researchers involved in the given program, equitable roles and responsibilities. In this way, CBPR demands shared participation, cooperation, and engagement of community members, researchers, and key stakeholders in a joint process (Minkler & Wallerstein, 2008). Likewise, in a person-centered approach, the therapist and client are engaged equitably to initiate and sustain the therapeutic relationship by recognizing the client's own unique contribution.

The purpose of this manuscript is to draw a useful association between CBPR and the person-centered approach for counselors interested in forming dynamic community relationships. Specifically, in the realm of prevention and research, a counselor can utilize the principles of CBPR to render community engagement for more sustainable outcomes. In the beginning sections of this manuscript, the history of CBPR as an approach to research will be outlined (Horowitz, Robinson, & Seifer, 2009). Prior obstacles to research will be addressed by expanding on CBPR principals, providing examples of CBPR for counselors, and describing how they coincide with a person-centered perspective for meeting those past challenges. From a person-centered orientation, we address the implications to counselors working in community agencies seeking to develop sustainable prevention programs. Counselors equipped with therapeutic skills and armed with a person-centered philosophical orientation will find a natural balance through the application of CBPR. By understanding the core principals of CBPR, we call to the profession of counseling to draw upon CBPR in order to retain the essential person-centered perspective for

improving the health and the well being of the communities where we practice.

Theoretical Background and Historical Foundation of CBPR

CBPR developed out of two research orientations labeled as the Northern and Southern traditions. Participatory research grew out of the Northern Tradition first proposed by Lewin who rejected the idea that study participants' voices and meaning making are excluded from the objectivist worldview (Lewin, 1948/1997). CBPR, emerging from a transformative research practice (Wallerstein & Duran, 2010), surfaced to challenge the positivist scientific viewpoint and rejected the notion that science and their participants are separate. Largely, the ideas followed from Talcott Parsons and his predecessors with an emphasis on equalizing power dynamics through their application of the scientific method in the real world to pave the way towards social progress (as cited in Minkler & Wallerstein, 2008). Research has been conducted in a manner that has often excluded the very communities affected by the health problem being studied (Minkler & Wallerstein, 2008). Research findings indicate that researchers who promote collectivist values and utilize their ability to reflect on their own culture have higher success towards collaborative communication (Oetzel, 1998; Oetzel, Burtis, Sanchez, & Perez, 2001; Yonas, Jones, Eng, Vines, Aronson, Griffith, & Dubose, 2006). In a similar manner to collaborative communication and CBPR contrast to positivist science, the person-centered therapeutic approach juxtaposes the deterministic, mechanistic, and pathologizing paradigms that pervade much of the helping professions (Elkins, 2008). The individual who experiences contact with the person-centered practitioner is not an object for study (Rogers, 1963); rather, the individual is conceptualized as the manifest of one's potential within a context or contexts.

Also, equally important to the development of CBPR, the Southern Tradition was aligned in the human rights, and social justice movements of Latin America, Africa, and Asia. These movements affirmed that knowledge being applied to communities does not originate solely from academia; rather, communities contribute, and should be valued for their inherent wisdom as they

participate in forms of inquiry (Minkler & Wallerstein, 2008). Rogers (1979a) contended that the person-centered approach, although criticized as a "soft" approach, has merit when working with the oppressed. Rogers (1979a) compared the work of Paulo Freire (1970), who worked with Brazilian workers to obtain their rights, with his successful work drawing upon the person-centered principles to illicit a community voice. The additional aspect of humanism, defined by Bell (2007), is aligned with social justice, a core tenet of CBPR, critically examining fair and equitable partnerships and their relational dynamics. Awareness of the dynamics of individual, community, agency and external dynamics is essential for a beneficial partnership that can increase community capacity (Minkler & Wallerstein, 2008).

Figure 1 presents a logic model of CBPR.

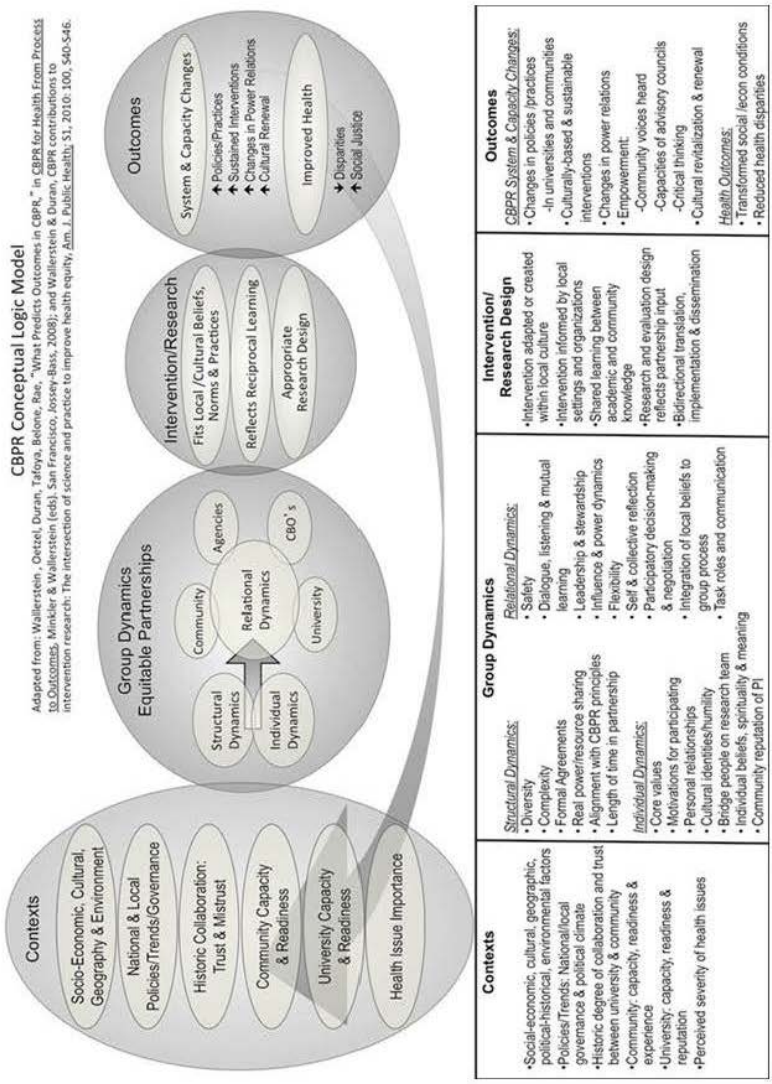
CBPR Conceptual Logic Model
Adapted from: Wallerstein , Oetzel, Duran, Tafoya, Belone, Rae, "What Predicts Outcomes in CBPR, " in: CBPR for Health From Process to Outcomes, Minkler & Wallerstein (eds). San Francisco, Jossey-Bass, 2008); and Wallerstein & Duran, CBPR contributions to intervention research: The intersection of science and practice to improve health equity, Am. J. Public Health; S1, 2010: 100, S40-S46.
Contexts
Socio-Economic, Cultural, Geography & Environment
National & Local Policies/Trends/Governance
Historic Collaboration: Trust & Mistrust
Community Capacity & Readiness
University Capacity & Readiness
Health Issue Importance
Group Dynamics Equitable Partnerships
Structural Dynamics
Individual Dynamics
Relational Dynamics
Community
Agencies
CBO's
University
Intervention/Research
Fits Local /Cultural Beliefs, Norms & Practices
Reflects Reciprocal Learning
Appropriate Research Design
Outcomes
System & Capacity Changes
Policies/Practices
Sustained Interventions
Changes in Power Relations
Cultural Renewal
Improved Health
Disparities
Social Justice
Contexts
•Social-economic, cultural, geographic, political-historical, environmental factors
•Policies/Trends: National/local governance & political climate
•Historic degree of collaboration and trust between university & community
•Community: capacity, readiness & experience
•University: capacity, readiness & reputation
•Perceived severity of health issues
Group Dynamics
Structural Dynamics:
• Diversity
• Complexity
• Formal Agreements
• Real power/resource sharing
• Alignment with CBPR principles
• Length of time in partnership
Individual Dynamics:
• Core values
• Motivations for participating
• Personal relationships
• Cultural identities/humility
• Bridge people on research team
• Individual beliefs, spirituality & meaning
• Community reputation of PI
Relational Dynamics:
• Safety
• Dialogue, listening & mutual learning
• Leadership & stewardship
• Influence & power dynamics
• Flexibility
• Self & collective reflection
• Participatory decision-making & negotiation
• Integration of local beliefs to group process
• Task roles and communication
Intervention/ Research Design
•Intervention adapted or created within local culture
•Intervention informed by local settings and organizations
•Shared learning between academic and community knowledge
•Research and evaluation design reflects partnership input
•Bidirectional translation, implementation & dissemination
Outcomes
CBPR System & Capacity Changes:
• Changes in policies /practices -In universities and communities
• Culturally-based & sustainable interventions
• Changes in power relations
• Empowerment: -Community voices heard -Capacities of advisory councils -Critical thinking
• Cultural revitalization & renewal
Health Outcomes:
• Transformed social /econ conditions
• Reduced health disparities

Figure 1

CPBR began to rise to meet the tide to balance social inequities, and embrace a mutually beneficial relationship for all partners involved. Wallerstein and Duran (2010) presented six challenges to traditional research that CBPR helps to address. The first challenge was *translating findings from highly controlled experiments to real world settings*. Furthermore, the original intention to improve a community's health lost its meaning and became distorted because the community could no longer see the value in the research findings or interventions deemed untranslatable to real life application. Of second importance was *incorporating the community, beliefs and or indigenous practices* into the research premise, design, implementation, and implications. The third challenge was *language* that could be deemed as incompatible terminology between a western or clinical perspective and a community's form of communication. An important related challenge particularly relevant for person-centered counselors is that *academics control the research agenda* which is incompatible with building a relationship. From a community perspective, the language utilized in academia may have been interpreted as exclusionary or something separate and untranslatable to real-world settings. The fourth challenge *shifts the powers dynamics* through bidirectional learning, shared resources, collective decision making, having beneficial outcomes for the community. This challenge is in sharp contrast to *business as usual* within universities where the research agenda is a priority and a community could be an afterthought to the research agenda. The fifth was *sustainability* when lack of consideration was given to community and/or agency resources that may be needed to implement or continue the project. In many circumstances research projects are not incorporated into the community over the long-term. The last, and crucial, element to building relationships was a *lack of trust* that had been fostered between communities as a result of these practices. Researchers seeking solutions to health related issues might have missed their mark and created distrust, resistance, historical memories of assimilationist policies, or betrayal.

Linking Person-Centered Counseling and CBPR

Given the overview and history of CBPR, this section considers the linkage of CBPR and person-centered counseling. For counselors interested in addressing research in the community, CBPR offers a complementary philosophy to person-centered counseling. This section illustrates the parallels in philosophies through the following areas: a) meeting the community and client where they are, b) fitting cultural beliefs and practices, c) language and translating research, d) shifting power dynamics, e) sustainability, and f) rebuilding trust.

Meeting the Community and Client Where They Are

In giving commitment to the CBPR process, the researcher allows the community to take the lead in the project and may discover new directions as a result. One of the core tenets of CBPR is to identify a particular health issue of importance to community members through a collaborative iterative process (Minkler & Wallerstin, 2008). Minker and Wallerstein (2008) argued the researcher may have to relinquish control of the intent to submit their results for publication if the end result would not be viewed as a benefit from a community perspective. For instance, if high rates of bullying are found within a given school and the community wishes not be stigmatized by this finding, the researcher may have to find alternative ways to share the results. The shared results would be mutually beneficial to the school children affected by bullying and the participants involved in the inquiry. On the other hand, it may not be beneficial if the results were published in the local newspaper that could run the threat of stigmatizing the students and the school.

One of the first steps for the CBPR researcher is to refrain from any action and *listen to* a community. Academics must let go of their personal agendas and identify the difficult questions that would be most beneficial to the community they are serving. For example, a focus group may be conducted with students, teachers, administrators, and/or parents to determine the unique perspectives of the school community. In the case of school bullying, such a

group would determine the extent of the problem and what interventions may be applicable given the norms of the school.

The researcher may be on his or her own timeframe given university protocols, grant specifications, and publishing demands and thus may feel frustrated when having to consider the needs of diverse communities (Minkler & Wallerstein, 2008). If the community is not ready for change, the researcher must let go of his or her agenda and meet the community where they are in their readiness for change (Minkler & Wallerstein, 2008). As transparent as the notion appears, the approach is very different from a traditional methodology that identifies and addresses a health problem, in some instances applies an intervention without community feedback, and neglects to communicate the results to the community in a meaningful way. Overlooking this pertinent component can lead to frustration, wasted resources, and increased resistance of the community to welcome outside interventions in the future (Minkler & Wallerstein, 2008).

Counselors learn quickly that they can only work at their client's pace and or within the realm of their client's willingness to change or confront conflicts. This process is accomplished through seeking to guide a client toward change rather than define the change. The alternative is to have the client internalize more feelings of oppression or isolation (Comstock, Hammer, Strentzsch, Cannon, Parsons, Salazar II, 2008). A counselor may think that she or he identified the problem and solution for their client. Yet, in developing a person-centered approach, attentive listening guides one's practice. At times, the counselor's perceptions are incongruent with what a client wishes. It takes many years of practice to develop the patience and humility to see things from another person's perspective. Even from a person-centered approach a counselor may have developed a specific treatment plan for his or her clients. However, the client may have alternative ideas about what she or he wants to address in a session. According to Kindsvatter, Osborn, Bubenzer and Duba (2010), counselors who understand the processes of change can facilitate for their clients in order to maximize their efforts.

Fitting Cultural Beliefs and Practice

In CPBR, the intervention must fit cultural beliefs, norms, and practices and also reflect reciprocal learning (Minkler & Wallerstein, 2008). For instance, according to Belone, Oetzel, Wallerstein, Tafoya, and Rae (2012), when working in communities during their alcohol and substance abuse prevention program for alcohol use among adolescents in Ramah Navajo, New Mexico, it was beneficial to train and impart knowledge to community members who could assume leadership positions. Equally important, was to have a diverse team that had built long-standing relationships with the community, including members of Native American descent (Belone et al., 2012). By entreating the community to participate, the researcher is imparting learning, building trust and sustainability, and increasing social justice (Belone et al., 2012). Most importantly, the community guides the research in ways such as utilizing a family system approach when addressing the issue, creating intervention materials in the local dialect, and reinforcing positive cultural norms to counteract the problem behaviors in the case of the Ramah-Navajo project. Within the CBPR framework the researcher must invest a significant amount of time to viewing the issue through a community's perspective to promote long-term effectiveness (Minkler & Wallerstein, 2008).

Most counselors are familiar with the notion that the client must direct the change from their belief system when seeking solutions to any self-identified issues in order for an intervention to be successful. In a community, these same dynamics and interactions play a part in creating effective prevention programs. Furthermore, Rogers, Kell and McNeil (1948) asserted that a counselor's purpose is to look at their client's frame of reference and understanding and leave out any external frame of reference in this process. Within the non-directive approach, being immersed in the empathic identification of the client and by perceiving their hopes and fears, the counselor cannot be concerned with diagnosis, how the relationship affects him/her, or the pace of the session (Rogers et al., 1948; Rogers, 1951). Rogers (1951) developed the idea further by clarifying that the empathic identification of the client is understood

through immersion yet, the counselor does not directly experience the feelings of the client. In this respect the counselor can act as an objective guide in the therapeutic process identifying with the client's worldview. Lambert and Bergin, (1994) and Miller and Rollnick (2002) contended therapeutic change is more valuable when clients attribute their progress to their own efforts. In person-centered counseling a therapist is invested in his or her client's worldview and in this reciprocal relationship the therapist is valued as the facilitator in the client's growth process.

Therapists must be willing to take the risk of losing themselves in the deep understanding of their client (Rogers, 1979b). The therapist facilitates client change through empathy and unconditional positive regard (Rogers, 1957). The empathy must be genuine and experienced by the client in order for change to occur. The empathy and unconditional positive regard includes both the positive and negative perceptions of the individual by the therapist (Rogers, 1957). Therefore, the relationship must be mutually respecting of the totality of the individual and not simply positively affirming yet, supporting and understanding the client's limitations. Geller, Greenberg, and Watson (2010) emphasized that being present with clients on a physical, emotional and spiritual level is essential for the therapeutic process. By being therapeutically present, the client is able to begin the healing process and feel supported in a safe environment (Geller et al., 2010). Rogers et al., (1948), looked at resiliency of delinquent youth and found that self-insight was positively correlated with later adjustment above factors such as economics, education, and heredity. Providing a welcoming space for self-directed reflection to occur unlocks the individual's capacity.

Throughout the relationship, the therapist possesses genuineness and transparency of spirit (Rogers, 1979b). Rogers (1951) believed that the attitude of the counselor must be upheld to view each client as having self-worth and dignity and the capacity for self-direction. Rogers (1951) asked the question, "Do we respect his capacity and his right for self- direction, or do we basically believe his life would be better guided by us" (p.20)? Within the process of CBPR on a larger scale, a person-centered counselor can also encompass the community's beliefs and practices drawing from

a person-centered philosophy to honor the communities' capacity to develop.

Language & Translating Research

Understanding the language of a community is essential to the adaptation of any intervention. Cultural nuances can play a key role in the decision of a community to embrace or reject a prevention measure, The language of academia can be difficult to translate and can lead to marginalization. For example, a research team uses the terms social determinants of health, which is a common expression in public health. Community members may not understand that expression and thus withdraw from conversations about health issues for fear of appearing uneducated. Instead, the issue could be talked about as factors, or even "things," that lead to good health. Such language is more accessible to a variety of people and thus community members can talk about these issues more readily. As researchers we provide opportunities for client success by examining how our research language contributes to marginalization and decreased social justice in the communities where we serve.

In addition to using accessible language, translating research is facilitated by building on the participants' strengths and perspectives. For instance, Rogers (1951) described The Area Projects developed by Clifford Shaw concerning delinquency; this project was successful because it was built upon the participants' strengths. Rogers (1951) argued that researcher approaches initiated outside the community's perspective would not be well translated and thus not effective: "attempts to produce these changes for the community by means of ready made institutions and programs planned, developed, financed, and managed by persons outside the community are not likely to meet with any more success in the future than they have in the past" (p.59).

Counselors coming from a person-centered perspective can be adept facilitators in the dynamic process of CBPR and foster effective communication by promoting a greater understanding of language and culture. Rogers (1995) found acting as an "expert" in the change process did not enhance the therapeutic relationship. When the *actualizing tendency* ignites Rogers (1979b) believed that

the individual is known to contain all the preexisting resources necessary for change. The therapist in turn is acting to direct the transition towards an evolutionary progression. The therapist cannot exist without the seed of change supplied by the client, and is also participating in a dynamic relationship. In order to develop trust the counselor must take into consideration the totality of a situation and the history of his or her client (Rogers, 1963). Ideally, both are invested and respected mutually in the relationship. Similar to the co-learning process described in CBPR, interacting with an individual, the therapist, through empathy and positive regard for the client, impacts the *actualizing tendency* to shift towards growth. Recognizing the potential of a community, respecting the input of its members, and using language that is accessible to all furthers the process of CBPR.

Shifting the Power Dynamics

CBPR is an iterative process constantly examining the roles, responsibilities and power dynamics of the participants (Wallerstein & Duran, 2010). Each community may have their own unique needs and although some of the principles are outlined, the process may need to change and adapt to meet the community's uniqueness (Minkler & Wallerstein, 2008). Traditionally, universities control research resources, budgets, and information; however, CBPR considers how the research may best benefit the community to sustain health changes by readdressing the priorities of the research agenda (Wallerstein & Duran, 2010). In addition, participants are credited by being listed as co-authors if publication is deemed acceptable; or in the case that it is not the participants may go on to report the findings alongside the researcher at conferences or trainings (Minkler & Wallerstein, 2008). Participants may also be compensated for their time therefore balancing some of the power dynamics that innately exists. (Minkler & Wallerstein, 2008). Thus, CBPR emphasizes the importance of balancing power in research to maximize equitable partnerships and most importantly, increase the effectiveness of the intervention.

Person-centered counselors are aware, when entering the therapeutic relationship, that each experience will be unique given

the complexity of the individual and their experiences. The therapist creates an accepting and egalitarian relationship with the client and works to eliminate an imbalance in power. Rogers (1995) asserted that permitting himself to understand and accept others as well as being open to the realities of life was essential. Rogers (1995) posited this reduced his desire to rush in and "fix" things. In sharing resources the CBPR approach looks at promoting change and not imposing upon it to bend to the researcher's will. Counselors understanding the promotion of growth and not the yielding to one's own format can be adept in the CBPR process.

Sustainability

When working within communities to address a potential health outcome, the community members should be engaged in the entire process from the inception to the end point. The relationship builds sustainability, and improves the health outcomes for the community in the long-term. Furthermore, by imparting knowledge to the community local capacity and ownership of the project can be developed (Wallerstein & Duran, 2010). If, for example, you are working on an HIV prevention project imparting skills to youth, those same participants could in turn train others to become facilitators. It may later be discovered that just as important to skill building was developing youth leadership. By recognizing the community's needs, sustainability of the project has a higher chance of success, resulting in the community taking the lead in the future rather than relying on the researcher to impart solutions.

As therapists, work with clients they find that it is essential for a client to be invested in the entire process. Often counselors are reminded that listening, while paying close attention to a client's identified obstacles, and meeting those challenges from their client's viewpoint, lead to a highly incorporated change process and maintenance of those changes over time (Prochaska, DiClemente, & Norcross, 1992). What are some of both the pros and cons for adopting a change from a community perspective? Exploring the meaning to a community will help direct the research and proposed intervention that can be sustained over time. Similarly, investing

time to engage with a community at the beginning of a project creates a solid foundation that benefits the community over time.

Rebuilding Trust

Over time the promises of research that did not hold true for a community led to a general historical distrust of researchers and outside entities directing health interventions. Most recently, blood samples were taken from the Havasupai Indians as part of a research project for diabetes through the University of Arizona (Mello & Wolf, 2010). It was later discovered that these blood samples were utilized for a number of alternate experiments other than improving the health outcomes for Havasupai suffering from a diabetes epidemic. The tribe was never informed of these additional intentions for research (Mello & Wolf, 2010). The news was devastating to the Havasupai and they later recovered their samples and filed a lawsuit. This mal-intended and misguided research reinforced feelings of violation of trust for the community. When looking at prevention and research, it is important to ask, "What historical factors play a role?" and "Does transgenerational trauma hold meaning for the community?" (Minkler & Wallerstein, 2008).

From a counseling perspective and person-centered approach, *trust* is essential in building a therapeutic relationship. The foundation of the person-centered approach rests on the foundation of trust in the relationship (Rogers, 1979b). Particularly, when working with indigenous, minority populations, and groups with a history of oppression, counselors become experts at adapting to new systems or beliefs to benefit their clients. Maximizing community agency, the person-centered approach seeks to value the client's experience. By examining the contexts of an individual, community, history, collaboration and community readiness, counselors can find new directions to work towards building trust.

Conclusions and Implications for Counselors

CBPR seeks to turn research inside out on its heel by adapting the practice of research to originate from a community perspective. Counselors working from a person-centered approach can transfer

this practice to a community in the same way they would toward a client who walks through their doors for therapy. Counselors need to retain the core elements of their practice as they move outside of their counseling offices and integrate into communities. This allows for the continued development of professional identity and ultimately helps counselors provide effective care. Counselors should take time to reflect before incorporating a new practice, belief, or intervention and continue to ask the questions, "Will this benefit my client?" or "Is this my own personal agenda?" CBPR researchers ask the essential questions, "How can CBPR research reduce health disparities?" and "What role does research play in intervention and policy change that contribute to the knowledge of a generation?" (Isreal, Schulz, Parker, Becker, Allen III, and Guzman, 2008). In order to reduce the growing health disparities existing in our communities, we need to begin to reflect on our practices, and look within for the solutions that may already exist. As counselors, we know that often clients possess the answers to their own questions and we are solely acting to ignite discovery in their own meaning. CBPR seeks to find the inherent wisdom of a community and bring it to light.

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