

A Person-Centered Approach to Individuals Experiencing Depression and Anxiety

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Abstract

The Person-Centered Approach (PCA) has been effectively used with clients experiencing a wide variety of severe psychiatric symptoms and is appropriate for those experiencing depression and anxiety. The authors outline a study, which investigated the effectiveness of the Person-Centered Approach (PCA) with individuals experiencing depression and anxiety. Participants were pre- and post-tested with the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI). Results are mixed regarding the effectiveness of the PCA and support the high co-morbidity rates of depression and anxiety symptoms reported in the literature.

Introduction

The preponderance of the literature on treatment of simultaneous depression and anxiety stress cognitive, behavioral, and drug therapy as either stand alone or primary interventions (Gladding, 1996; Jongasma & Peterson, 1999; Maxman & Ward, 1995; Seligman, 1990). The Person-Centered Approach (PCA) is often touted as inappropriate for addressing deep issues and ineffective in bringing about lasting change with seriously troubled individuals (Gladding, 1996; Maxman & Ward, 1995). Theory and research do exist, however, supporting the use of the PCA with individuals diagnosed with a wide range of severe psychiatric symptoms in a variety of populations.

A sampling of this literature shows the use of the PCA with individuals diagnosed with conduct disorder (Cochran & Cochran, 1999), antisocial personality disorder (McCulloch, 2000; McCulloch, 2002), schizophrenia (Rogers, Gendlin, Kiesler, & Truax, 1967; Sommerbeck, 2003), developmental disabilities (Demanchick, Cochran, & Cochran, 2003), and psychoses/near-psychoses (Sommerbeck, 2003). Given the use and effectiveness of the PCA with clients experiencing a wide variety of psychiatric symptoms, this study proposes a pre- and post-test design investigation into the effectiveness of the PCA with clients experiencing depression and anxiety.

Method

A masters-level counselor conducted this study at an outpatient mental health center. The Beck Depression Inventory Primary Care Version (BDI-PC), a seven-item version of the Beck Depression Inventory (Beck, 1996; Beck, 1993), and the 21-item Beck Anxiety Inventory (BAI) (Beck, 1990) were used to pre-test clients. Clients were post-tested with

the BDI-PC and the BAI. The reliability, validity, and clinical utility of short form measures (in general) and the BDI-PC (specifically) are supported in the literature (Arroll, Khin, & Kerse, 2003; Beck, Steer, & Garbin, 1988; Del Mar & Glasziou, 2003; Groth-Marnat, 1990; Steer, Cavalieri, Leonard, & Beck, 1999). Reviews of the BAI show it to be a highly reliable, valid, and useful assessment tool (Impara & Conoley, 1996). The Personal Account Form (PAF) was developed for use in this study to assess participant impressions of the psychotherapeutic experience within four domains of change: (1) depression-symptom changes, (2) anxiety-symptom changes, (3) medication changes, and (4) life changes. The PAF was administered at the end of treatment.

Participants

Twenty-five participant candidates were administered the BDI and BAI pre-tests. Nine (36%) did not meet inclusion criteria; sixteen (64%) did. Inclusion as a participant required at least a moderate score on the BDI for depression and some symptoms of anxiety or a moderate score on the BAI for anxiety and some symptoms of depression. Present or prior clinical diagnosis did not affect inclusion. Although the initial sample of 25 participants was small, the co-morbidity rate of 64% is consistent with claims of high rates in the literature (Coplan & Gorman, 1990; Enns et al., 2001).

Treatment

Participants received individual Person-Centered counseling. The counselor's attitude was one of facilitating an atmosphere that provided Rogers' (1957) six necessary and sufficient conditions for therapeutic change. The counselor's focused on being with clients and attending to and reflecting client expressions empathically, genuinely, and respectfully (Bozarth, 1998; Brodley, 1998, 1996; Kirschenbaum, 2003; McCulloch, 2003a; Rogers, 1986). Questioning was avoided, as Rogers and other Person-Centered clinicians have theorized and practiced (Gundrum, Lietaer, Hees-Matthijssen, 1999; Kirschenbaum, 2003; McCulloch, 2003b; Rogers, 1951). Clients determined the frequency of their sessions. After six weeks of counseling, participants were re-administered the BDI and the BAI and completed a PAF. The counselor met with all participants to discuss results of counseling, the pre- and post-tests, and the research.

Results and Discussion

Eleven of the sixteen participants did not complete the study (four dropped out of counseling; three did not schedule counseling sessions within the study limits; one was hospitalized for mental health ailments; one was hospitalized for physical ailments; one transferred to another counselor; one arrived late for the session in which the post-test would be given and reported that she would be incarcerated shortly).

The mean scores of the five participants who completed the study were: BDI—Pre-test, 11.80 (range, 9-16); Post-test, 7.00 (range 4-9); BAI—Pre-test, 23.60 (range 12 – 36); Post-test, 16.60 (range 7 – 36). Overall depression scores decreased pre-post by 40.68%, and overall anxiety scores decreased pre-post by 29.66%. Scores for four of the five participants (80%) decreased pre-post by at least one descriptive category on both the

BDI-PC and the BAI. Two participants experienced a greater reduction in depression symptoms and two experienced a greater reduction in anxiety symptoms. Three (60%) reported on the PAF that counseling had been helpful.

It might be said that a study's design flaws and confounds can be "worth their weight in gold" when analysis of flaws contributes to the literature or, despite the flaws and confounds, valuable data result. While the results support the conclusion that the PCA is effective with persons with depression and anxiety, design problems and confounds call into question whether the counseling sessions were a factor in the results. The study yielded no conclusive gold. Its flaws include:

Low counseling session frequency. While research exists showing that the greatest efficacy in counseling occurs early in therapy, with fifty per cent of clients recovering within eleven sessions (Howard, Orlinsky, & Lueger, 1994), the number of sessions for each participant in this study was considerably lower—one or two sessions.

Small sample size. Increased sample size would have offered the obvious benefits of increased possibility for higher counseling session frequency, decreased impact of dropouts and "no-shows," and greater power.

Unmeasured life events. The extent to which sobriety, medications, and major life events factored into participant change was not assessed. Doing so would have provided data to further specify the degree to which the PCA factored into participant change.

Counselor competency was not assessed. Assessment of counselor competency may have helped to establish whether the PCA was actually delivered at a high level. Supervision during the study may have been helpful in assuring the consistency and quality of counseling.

Lack of data on dropouts. Analysis of all the pre-test scores for all study-qualifying participants would have allowed comparative analysis of scores for those who completed versus did not complete the study. Resulting data might provide information on the quality of the remaining sample.

Inconsistencies among measures. Results from this study are unclear as to the relationship between BDI and BAI results and participant statements regarding counseling. For example, one participant stated that she did not believe counseling was helpful, while her BDI/BAI results showed reduced depression and anxiety symptoms. Further research that includes the use of a standardized instrument with validity measures may be helpful in assessing the relationship between client perceptions of PCA and the reported degree of depression and anxiety symptoms.

Conclusions

The results of this study are inconclusive regarding the effectiveness of the PCA with depressed and anxious clients. The results do support the claims of a high co-morbidity rate of depression and anxiety reported in the literature. Areas of concern in this study include: session frequency, sample size, validity measures, counselor competency, and lack of analysis of pre-test scores for all participants. Future research investigating differences in the effect of PCA on depression versus anxiety symptoms may be helpful in identifying degrees and patterns in both sets of symptoms.

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