

The 180 Degree Turn: Finding the Human Side of Mandated Counseling

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Abstract

This article discusses how cultural changes in the United States led to an emergence of a number of mandated treatments intended to address the specific concerns of substance abuse, sexual abuse, and domestic violence. A brief history of interventions for each of the respective fields is described and a trend toward more humanistic treatment methods is noted. The similarities between the Person-Centered Approach and current trends in these fields are explained.

Keywords: Person-Centered Approach, substance abuse, sexual abuse, domestic violence

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While Carl Rogers (1951) was discovering the Person-Centered Approach to Counseling in the middle of the 20th Century, the United States sat on the edge of a cultural revolution that would shape the field of counseling and psychotherapy in ways that no one could scarcely imagine. Within 15 years of the initial publications of Carl Rogers explaining his new Person-Centered Approach, drug abuse sky-rocketed (White, 1998) and the second wave of the Feminist movement began to target domestic and sexual violence against women (Gamble, 2001). With these sharp societal changes, new laws emerged that condemned drug abuse and criminalized abuse of women and children. Although most would agree that these changes were a strong positive step in a civilized society, the sharp departure from previous societal views led legal and medical professionals searching for a way to manage these problems. Rather than evaluate the theories that were widely used in psychotherapy at the time, professionals in the fields of addiction and abuse began to search for treatment alternatives that would directly challenge these emerging problems. What would be discovered when implementing and researching these highly structured interventions in the last 40 years, is similar to what Carl Rogers found when he first started to develop the Person-Centered Approach. This paper charts the evolution of practice in the Addiction and Violence fields and will show how those respective fields have reached the same conclusion that Rogers did nearly 65 years ago: It is the person who matters (Rogers, 1951).

Substance Use Treatment

Modern drug and alcohol use began to take shape in the 1960s. Prior to that time, addiction was seen as a flaw in character or a self-control problem and the field was largely dictated by self-help groups like Alcoholics Anonymous (AA) (White, 1998). In 1980, the American Society of Addiction Medicine (ASAM) issued a definition of addiction treatment which described it as:

the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug addiction, and which is designed to enable the affected individual to achieve and maintain sobriety, physical, spiritual and mental health, and a maximum functional ability (Public Policy Statement on Treatment for Alcohol and other Drug Addiction, 1980, p.1).

Initial practices to treat addiction involved incarceration, long-term hospital stays, electroconvulsive therapy, group therapy, cognitive treatments, and medication (White, 1998). Relapse Prevention (RP) treatment was developed in the 1980s in the substance abuse field by Marlatt and Gordon (1985). This intervention was based on the belief that addiction was a byproduct of social learning rather than a biological disease. The goal of Relapse Prevention was to help clients maintain abstinence after treatment because 80% of substance abusers relapsed within just 12-months of treatment (Hunt, Barnett, & Branch, 1971). Central to Relapse Prevention is the theory of a Relapse Cycle where relapse is the result of small knowable events that occur over time rather than in a sudden and uncontrollable manner. The client's goals in Relapse Prevention treatment are to identify risk factors that drive the substance user toward relapse and to develop self-management strategies to avoid or cope with these risks.

Although some of these practices remain, the substance abuse field has evolved significantly in the last 30 years. Currently, medications have helped to maintain the sobriety of long-term opiate abusers and in many places, drug treatment courts have replaced the practice of criminalizing substance users to ensure that substance abusers are not incarcerated without the chance of treatment. Most significantly, widespread beliefs that substance abuse treatment need only be cognitive in nature are finally being challenged. Although, group therapy and psycho-education are still standard practice in substance abuse treatment, professionals have consistently been plagued with problems related to a client's motivation to change. If a client lacks motivation, they are unlikely to engage, comply with and succeed in treatment (Center for Substance Abuse Treatment. (1999). Because Cognitive Behavioral Treatments (CBT) and Relapse

Prevention treatment protocols do not specifically address motivational problems, professionals who set policy in the substance abuse field sought a more humanistic method to engage clients in meaningful change. To achieve this end, the current method of choice in substance abuse treatment is now Motivational Interviewing.

Motivational interviewing directly draws on Roger's (1961) humanistic perspective of psychology. In this intervention, clients are viewed as the experts in their own lives and the goal of treatment is to invoke discussion of their perspectives on change. Rather than a practitioner imposing arguments for change onto the client, the client is invited to use his or her own values to contemplate behavior change (Rollnick & Miller, 1995). When clients are open to give voice to their own personal conflicts the potential for re-evaluation is strongest.

Miller and Rollnick (2002) list four principles that act as a guide to counseling in Motivational Interviewing. First, it is necessary for counselors to express empathy for the client and his or her struggles. If the client feels heard and understood, there is a greater chance of a client sharing his or her experiences in depth (Miller & Rollnick, 2002). Second, the counselor listens for discrepancy in the client's language that may help the client understand conflicting feelings. These discrepancies are often seen as incongruence between the client's reported goals and current behaviors. Third, counselors are asked to 'roll with resistance' and to accept that if a client is not ready to make change that this is part of the treatment process (Miller & Rollnick, 2002). Counselors are encouraged to invite clients to examine new points of view, and are careful not to impose their own ways of thinking onto clients. Finally, the counselor seeks to support self-efficacy by conveying that the clients have within themselves the capabilities to change.

Burke, Arkowitz & Dunn (2002) studied 26 different articles that offered evidence of the efficacy of Motivational Interviewing across a number of domains. They found that 60 percent of studies showed that Motivational Interviewing facilitated a significant effect on behavior change and the most significant outcomes were in substance abuse treatment. Similarly, in a meta-analysis by Gossop (2006), 75 percent of studies showed that Motivational Interviewing resulted in significantly improved outcomes in substance abuse.

Motivational Interviewing draws heavily on the work of Rogers (1961), with the core conditions of unconditional positive regard, congruence, and empathy being central to the approach. Motivational Interviewing reflects a realistic view of motivation, and an alternative approach to coercion or persuasion that Rogers himself was looking for when he developed the Person-Centered Approach. Although, Motivational Interviewing is different from the Person-Centered Approach in several ways, the adoption of this intervention and subsequent validation of its efficacy, reinforce what many of us in the Person-Centered Community have known for more than half of a century: the core conditions are the fuel of change.

Sex Offender Treatment

Sexual offense specific treatment began to emerge in the United States as a result of the momentum of the Women's Movement in the 1980s (D'Orazio, Arkowitz, Adams, & Maram, 2009). Although laws that condemned sexual abuse had been enacted much earlier in the United States, pressure from the Women's Movement demanded consequences for abusers and insisted that legal and medical professions move away from the previous cultural practice of blaming victims for abuse. For the first time in national history, societal attention was focused on the problem of abuse against women and children and how to punish, manage, and hopefully rehabilitate those offenders. It is important to note that there was not a significant rise in abuse against women and children in the last 40 years, rather, a new landscape emerged from cultural pressure that demanded that those who perpetrate abuse against others be strongly sanctioned for their behavior.

In the beginning of sexual abuse treatment, and to some extent today, the major approach to the treatment of sex offenders in North America is the risk-need model (D'Orazio, 2013). This treatment perspective is concerned with risk management, where the primary aim of treating offenders is to avoid harm to the community (Andrews & Bonta, 1998; Gendreau, 1996). The hope was that by identifying and managing various risk factors, the offending rates would be reduced. An example of the risk-need approach would be if an offender was receiving treatment because he had a sexual relationship with a teenage girl. The risk management model would encourage this

offender to avoid teenage girls and limit any activity that would remotely place the offender in proximity to teenage girls. In the 1980s, Cognitive Behavioral Therapy (CBT), pioneers like Gene Abel and Judith Becker popularized CBT in the field of sexual abuse treatment. Janice Marques, attempted to integrate the two applications of abuse treatment, the Relapse Prevention (RP) approach of the substance abuse field and CBT, thereby creating the Relapse Prevention Model of Sexual Offender Treatment (Marques, 1982). Twenty years later, this model of treatment suffered a setback as substantial data began to indicate Relapse Prevention's lack of effectiveness in reducing sexual offense recidivism (Marques, Day, Nelson & Alarcon, 2000). This came as a deep disappointment to sexual offender treatment programs across the U.S. and it forced the field to set a new path toward improving treatment outcomes (D'Orazio, 2013).

New models of sexual offender treatment are focused on the enhancement of offenders' self-esteem and self-efficacy in order to help them improve the quality of their life, and by doing so, reduce their chances of committing further crimes against the community when they are released from prison. One of the most popular of these is the Good Lives Model (Ward, 2002). The core idea of this approach is that all meaningful human actions reflect attempts to achieve primary human goods (Ward, 2002). These goods manifest in actions, states of affairs, characteristics, experiences, and states of mind that are viewed as intrinsically beneficial to human beings. These goods can be a sense of acceptance, a feeling of being loved, an intrinsic sense of value and efficacy, and meaningful activities and relationships. Although these goods are clearly influenced by culturally derived beliefs, values, and norms (D'Andrade, 1995), the underlying point is that how we seek our needs will have an impact on the quality of our lives and well-being. In the case of criminal behavior, the problem resides in the means used to secure goods. For example, if an offender seeks intimacy and mastery by engaging in a sexual relationship with a child, this inappropriate way of seeking these goods are not likely to result in higher levels of well-being. In the Good Lives Model, offenders are invited to become reacquainted with their basic human needs and offered an opportunity to examine how they are meeting those needs and why (Ward, 2002). For example, this approach would encourage an offender to examine why

he has chosen to meet his intimacy needs with children, rather than just encourage him to avoid children.

In summarizing this shift in focus toward a more humanistic model of treatment, D’Orazio (2013) posited that the shortcomings of the Relapse Prevention approach was that it did not sufficiently focus on an individual’s internal change process. She further posited that “impingements of freedom, harsher institutional conditions, and aversive consequences for unfavorable treatment behavior is often effective at motivating superficial treatment compliance, although undermines long lasting treatment efficacy” (p. 3). D’Orazio (2013) further suggested that in treating individuals who had committed sexual offenses, treatment providers and the criminal justice system were invoking the same behaviors that it was hoping to discontinue in the offenders. By coercing clients with high levels of external control, the system is, in a sense, creating a similar experience to what offenders instill in their victims. D’Orazio concluded that any treatment that favors external motivation over internal motivation for change “is sacrificing long lasting change for short-term obedience” (p. 3).

Newer methods of treatment in the sexual abuse field posit that (a) increasing sexual offenders’ self-esteem has a facilitating effect on most of the primary targets of sexual offender therapy (Marshall, Cripps, Anderson, & Cortoni, 1999), (b) working collaboratively with offenders in developing treatment goals results in a stronger therapeutic alliance (Mann & Shingler, 2001), and (c) displaying empathy and warmth, as well as providing encouragement and rewards for progress, are therapist features that facilitate the change process in sex offenders (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson 2003). D’Orazio (2013) offered the following five steps as recommendations for effective sexual behavior treatment going forward: 1) The counselor encourages the client to focus on ‘self,’ being open to assessing and treating old wounds. Too often in the past, counselors were instructed to address behavior and not allow clients to go too deeply into their personal history. 2) Counselors should not be afraid to highlight affective factors, and not yield to the temptation to utilize solely cognitive methods. 3) The counselor should cultivate empathy for the abuser which facilitates an improved landscape for change. 4) Counselors are encouraged to embrace the wholeness of a person and the complicated interaction of thoughts,

feelings, and behaviors by avoiding cookbook approaches to treatment. 5) Counselors would benefit from being mindful of self-care and maintaining optimism.

Although we would never suggest that these interventions are the same as the Person-Centered Approach, it is clear that like Rogers, the sexual abuse field has figured out that highly structured interventions that place the counselor in the expert role with all of the power, will not result in lasting therapeutic change. A strong therapeutic alliance is vital to the process, and also like Rogers, sex abuse researchers have concluded that they must ensure that the client and his or her experience is most important when trying to affect meaningful change. By concluding that warmth, empathy, and the prizing of a person's internal experience matter in treatment, these researchers and clinicians are making a similar turn that Rogers did when he developed the Person-Centered Approach.

Domestic Violence Treatment

Along with the emergence of sexual offender treatment, programs to reduce the prevalence of domestic violence also emerged in the early 1980s. Because there were no programs prior to this time, researchers taking part in The Domestic Abuse Intervention Project met in Duluth, Minnesota to form a multidisciplinary intervention to address the problem of domestic violence (Pender, 2012). The model that was developed as a result of this project came to be known as the Duluth Model of Domestic Violence Treatment, which is one of the most widely used models today. Delivered in a structured group format over a period of 26 weeks, the program's philosophy is intended to change batterers' attitudes and behavior in relation to their intimate partnerships by challenging how they think about concepts such as male privilege, respect, coercion, and intimidation (Haken, 2010). Using the power and control wheel, activities, and video clips, batterers are encouraged to reconsider their beliefs and develop action plans that eliminate violence as an option in their intimate relationships.

The other most widely used batterer intervention relies mainly on principles of Cognitive Behavioral Treatment (CBT) which views violence as a learned behavior. CBT interventions for domestic violence target the offender's thinking about violence and challenge

cognitive distortions that have led to maladaptive violent behaviors. Additionally, domestic violence is addressed by developing alternatives to violence and improving social skills and anger management (Babcock, Green & Robie, 2004).

A meta-analysis conducted in 2013 measured 49 effect sizes from a sample of 18,941 batterers (Arias, Arce & Vilariño, 2013). The results of this research showed that both the Duluth Domestic Violence Model and CBT treatments had no significant treatment effect. The results of this meta-analysis also evaluated other interventions referred to as “Other Types of Intervention” (OTI) covering a wide variety of treatment programs such as Psychodynamic counseling, Anger Management, and Mind Body Bridging (Arias et al., 2013). This meta-analysis concluded that the techniques and methods that were applied in the interventions that involved active, focused, collaborative learning, achieved better results than either of the main interventions widely used today.

Domestic violence treatment has yet to officially turn in a more Person-Centered direction. In 2008, Weaver explained that because men are more likely to be resistant to therapeutic engagement and less likely to demonstrate empathy, they are often relegated to authoritarian, directive, and rigidly structured approaches. Weaver (2008) argued that despite criticisms that the Person-Centered method is not rigorous enough, she believed that the core conditions, when embraced by a clinician with knowledge of gender and power issues, could be an extremely effective intervention in promoting batterers’ movement toward responsible behavior. What is most curious is that the meta-analysis described in the paragraph above found no evidence to suggest that an intervention’s level of structure, rigor, or cognitive challenges translated into effective treatment yet domestic violence treatment programs are still hesitant to move toward a more humanistic approach because it does not contain these ineffective methods. What is understood are that collaborative approaches appear to be more promising, but unfortunately, there are few interventions that have attempted collaborative methods in domestic violence treatment.

Conclusion

Despite researchers' best attempts to develop interventions that are highly specified to treat various societal problems, it appears that each of these fields have returned, or are starting return, to an understanding that there is no effective treatment without the heartfelt consent of the client. Legal mandates and stiff penalties can force compliance, but it is only a collaborative, empathic, and understanding therapeutic alliance that is likely to promote meaningful change. The Person-Centered Approach is often the target of criticisms of more structured interventions arguing that by not directly challenging dysfunctional beliefs that the clinician is somehow endorsing those beliefs. In the end, it appears that anyone who levels that criticism fails to understand the principles behind the Person-Centered Approach. In Rogers' words, "when the human being is inwardly free to choose whatever he deeply values, he tends to value those objects, experiences and goals which make for his own survival, growth and development and for the survival and development of others" (Rogers, 1964, p. 183). Rogers would argue that there is innate goodness in substance users, sexual offenders, and domestically violent men and that the necessary and sufficient conditions for change apply to these people just like anyone else. When Rogers shared his famous "potato story" he described how the potatoes that were in his cellar, trying to sustain life, were similar to people who had troubled pasts:

the potatoes would begin to sprout - pale white sprouts, so unlike the healthy green shoots they sent up when planted in the soil in the spring. But these sad, spindly sprouts would grow two or three feet in length as they reached toward the distant light of window. They were, in their bizarre, futile growth, a sort of desperate expression of the directional tendency I have been describing. They would never become a plant, never mature, never fulfil their real potentiality. But under the most adverse circumstances they were striving to become. Life would not give up, even if it could not flourish. In dealing with clients whose lives have been terribly warped, in working with men and women the back

wards of state hospitals, I often think of those potato sprouts. So unfavorable have been the conditions in which these people have developed that their lives often seem abnormal, twisted, scarcely human. Yet the directional tendency in them is to be trusted. The clue to understanding their behavior is that they are striving; in the only ways they perceive as available to them, to move toward growth, toward becoming. To use the results may seem bizarre and futile, but they are life's desperate attempt to become itself. It is this potent constructive tendency which is an underlying basis of the person-centered approach (p. 2-3).

If we were to apply this analogy to the fields of substance abuse, sexual abusers, and domestic violence, Rogers would not expect us to reason with the potatoes or provide them workbooks and a structure to try to turn their white shoots into green shoots while struggling for life in the basement. Rather, Rogers would have suggested that if we provided the potatoes with a healthier environment, that they would find their own way to a better experience. It would have been validating for many of us in the Person-Centered community if these principles were accepted and understood as these interventions were being designed. However, there is a satisfaction that comes from watching Rogers' discoveries be rediscovered by those who originally believed they knew better than the client.

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