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Research Article

The fundamentals of the Person-Centered Approach in the work of Carl Ransom Rogers and their relevance to the clinical practice of Family and Community Medicine

Os fundamentos da Abordagem Centrada na Pessoa na obra de Carl Ransom Rogers e a relevância deles para a prática clínica da Medicina de Família e Comunidade

Los fundamentos del Enfoque Centrado en la Persona en la obra de Carl Ransom Rogers y su relevancia para la práctica clínica de Medicina Familiar y Comunitaria

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Abstract

The Person-Centered Approach (PCA) is a structuring clinical tool of Family and Community Medicine (FCM), and its teaching is an essential part of Medical Residency Programs in this specialty. The theoretical foundation of PCA is based on the work of the North American psychologist Carl Ransom Rogers, considered the precursor of Humanist Psychology. The purpose of this article is to present the fundamentals of PCA in Rogers' work and their relevance to the clinical practice of FCM. The main concepts are presented in three points: 1) Actualizing (or formative) tendency; 2) PCA and the production of insight; and 3) The three key concepts (or key attitudes) of PCA: congruence, unconditional positive regard, and empathetic understanding. The perspective of construction and improvement of the humanist clinic, through Roger's work, is alive and, precisely for this reason, this reference offers enormous potential for qualifying the FCM clinic.

Keywords: Patient-centered care. Family practice. Psychological theory.

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Resumo

A abordagem centrada na pessoa (ACP) é uma ferramenta clínica estruturante da Medicina de Família e Comunidade (MFC), sendo o seu ensino parte essencial dos programas de residência médica nessa especialidade. A fundamentação teórica da ACP está alicerçada sobre a obra do psicólogo norte-americano Carl Ransom Rogers, considerado o precursor da Psicologia Humanista. O objetivo deste artigo é apresentar os fundamentos da ACP na obra de Rogers e a relevância deles para a prática clínica da MFC. Os principais conceitos são apresentados em três pontos: 1) tendência atualizante (ou formativa); 2) ACP e a produção de *insight*; e 3) os três conceitos-chave (ou atitudes-chave) da ACP: congruência, consideração incondicional positiva e compreensão empática. Existe viva, pela obra de Rogers, a perspectiva de construção e aperfeiçoamento da clínica humanista, de maneira que, por essa razão, justamente, essa referência oferece um enorme potencial de qualificação da clínica da MFC.

Palavras-chave: Assistência centrada no paciente. Medicina de família e comunidade. Teoria psicológica.

Resumen

El Enfoque Centrado en la Persona (ECP) es una herramienta clínica estructurante de la Medicina Familiar y Comunitaria (MFC), y su docencia es parte fundamental de los Programas de Residencia Médica en esta especialidad. El fundamento teórico del ECP se basa en el trabajo del psicólogo norteamericano Carl Ransom Rogers, considerado el precursor de la Psicología Humanista. El propósito de este artículo es presentar los fundamentos del ECP en el trabajo de Rogers y su relevancia para la práctica clínica de la MFC. Los conceptos principales se presentan en tres puntos: 1) Tendencia de actualización (o formativa); 2) ECP y producción de *insight* y 3) Los tres conceptos clave (o actitudes clave) del ECP: congruencia, consideración positiva incondicional y comprensión empática. Está viva, a través del trabajo de Rogers, la perspectiva de construcción y mejora de la clínica humanista, por lo que, precisamente por eso, esta referencia ofrece un enorme potencial para calificar la clínica de la MFC.

Palabras clave: Atención dirigida al paciente. Medicina familiar y comunitaria. Teoría psicológica.

INTRODUCTION

The person-centered approach (PCA) is a structuring clinical tool in Family and Community Medicine (FCM), and its teaching is an essential part of medical residency programs in this specialty.[1-6]

In the context of FCM, PCA has been studied and taught through the person-centered clinical method (PCCM), a systematization proposed by Stewart et al.[7] and consisting of four interactive components: "exploring health, illness and the experience of illness", "understanding the person as a whole", "elaborating a joint plan for the management of problems", and "intensifying the relationship between person and doctor".

Although Rogers' influence on the construction and practice of PCA and, consequently, of the PCCM is recognized, little emphasis has been given to the relevance of his concepts to the clinical practice of FCM. Some are potentially important for their qualification, especially with regard to the better performance of the component "intensifying the relationship between person and doctor" of the PCCM, that is, the person-doctor relationship.

Thus, after a brief overview of his work, his potentially relevant concepts for the clinical practice of FCM will be presented here, highlighted in three points:

1. actualizing (or formative) tendency;
2. PCA and the production of insight; and
3. the three key concepts (or key attitudes) of PCA: congruence, unconditional positive regard, and empathic understanding.

Rogers and the development of the humanist perspective

For his books *Counseling and Psychotherapy*, published in 1942, and *Client-Centered Therapy*, of 1951, the American psychologist Carl Ransom Rogers (1902–1987) is considered the precursor of Humanistic Psychology.

Rogers first presented the theory of Non-Directive Psychotherapy (or Non-Directive Counseling) at a lecture given at the University of Minnesota in 1940. At that time, working with children, he observed in them a positive potential for development, which based his non-directive approach. According to this, it was up to the therapist to offer the right conditions for this potential to develop and, as it was revealed, to guide the approach and treatment. This perspective contrasted with the directive perspectives, in which the therapist was the one who indicated the course of approach and treatment according to the aspects, which, in his assessment, met the demands in question.

In *Counseling and Psychotherapy*,[8] Rogers shows, in a pioneering way, a systematic analysis of his psychotherapeutic approach through the transcription of consultations, and in *Client-centered Therapy*,[9] an expression coined by him, he presents his theory about psychotherapy and personality, as well as research that corroborated his approach. Thus, in this follow-up, he replaces his non-direction perspective with a customer-centered one.

In the following years, the author continued to broaden his scope of approach, applying it to other fields of knowledge, including education, sociology, and politics, in notable books: *On Becoming a Person*,[10] from 1961, *Freedom to Learn*,[11] of 1969, and *On Personal Power*,[12] of 1977, a book in which he cites for the first time the term “person-centered approach”.

In *A Way of Being*,[13] from 1980, Rogers addresses his approach to a philosophy of life, a way of being. It also presents a retrospective of the evolution of his thinking, eventually reviewing the changes in terminology used throughout his work — psychotherapy or non-directive counseling, client-centered therapy, group-centered psychotherapy, group-centered management and leadership, and student-centered teaching (all expressions and concepts that were shaped based on his work) — and concluding: “as the fields of application grew in number and variety, the label Person-Centered Approach seems to be the most appropriate”.[13]

Rogers was no longer referring only to psychotherapy, but also to social relationships and interactions and, above all, to a point of view, to “a way of being”, of being in the world, to any situation in which the intention was to develop a person, group or community. The term PCA would be considered, since then, the synthesis of his work.

The potential of Rogers’ work is well signaled by Moreira[14] when he recognizes it as a “dense axis, which deserves special attention with regard to the continuity of its theoretical construction in the direction of a humanist, phenomenological, critical, and expanded clinic, which prioritizes the acceptance of otherness”.

First point: actualizing (or formative) tendency

Rogers initially formulated the concept of the “actualizing tendency” — the natural, inherent tendency that is present in all human beings, toward complete development, in a positive direction —, which became not only his starting point, but above all, as will be seen throughout his work, the axis of all his thinking.[8,9,14]

In *On Personal Power*, the author extends his perspective to all living organisms: “there exists in every organism, at any level, an underlying flow of movement for a constructive realization of its intrinsic possibilities.”[12] And it will be through countless examples from biology and the physical sciences, present in *A Way of Being*, that he will further expand the concept to that of a “formative tendency”, now identified in the universe as a whole.[13]

For Rogers, therefore, there is in every human being, as in every being, a tendency to actualize their potential for development or maturation, with symptoms (or dysfunctions or diseases) corresponding to their distortion, although never to their annihilation. It would be up to the therapist (or health professional) to create facilitating conditions for the updating (or formative) tendency to return to its original flow, providing the continuity of the person’s maturation.

In this way, the premise of the PCA, recognized by Rogers in *On Personal Power* — that the human being is an organism worthy of trust — makes the actualizing (or formative) tendency, consequently, the foundation on which the PCA is built.[12]

Second point: person-centered approach and the production of insight

In *Counseling and Psychotherapy*,[8] Rogers considers that the search for a new orientation and reorganization of the self is the primary objective of the consultation and that the main question, which is presented based on this search, is to know how health professionals may favor this increase in self-understanding, this new orientation toward new goals.

Rogers argues that the fundamental technique, which leads to insight on the part of the person, requires from the health professional a maximum degree of self-restraint (and not initiative of action), so that it will be by encouraging people to express feelings and attitudes that they will, spontaneously, achieve an understanding intuition.[8]

For the author, the deepest insight and, therefore, the most useful one, the one that proves to be most effective in the reorganization of the self, is what is expressed spontaneously. Therefore, the main objective of health professionals is to help people to abandon any kind of defense, any impression that there are feelings and attitudes that should not be openly expressed, any concern about the fact that the health professional may censor them. If this objective can be achieved, people will then be free to look at the total situation in its true colors, without having to justify or protect themselves, becoming able to see relationships clearly and to recognize the impulses, until that moment, repressed within.

In the follow-up, as people reveal themselves, more and more fully throughout the interviews, the health professional begins to develop an insight into the subjects’ problems, starting to also experience, from that moment on, a great temptation to inform the subjects about their model of conduct, to interpret their actions and their personality. It is precisely here that Rogers warns: “the more adequate the interpretation, the more likely the defense resistance will be”.[8] Not giving in, therefore, to the temptation to interpret and recognize that insight is an experience to be developed and that it cannot be imposed become fundamental aspects of the therapeutic process.

Insight, according to Rogers, is a new way of perceiving the self, the relationships, and the choices. Maturity happens when people discover that their growth can be a rewarding kind of satisfaction. Success in psychotherapy occurs when people become able to face choices in a free way, without defensive attitudes, preferring the satisfactions that come from a generally more difficult path, achieved in the long term, to the more immediate ones. As the choice for change is precisely the way of responding to current demands,

which means a postponement of satisfactions (which are being partly achieved by the adaptive symptom in question), it is that this choice, which represents the success of the therapy, cannot be given by a type of directive therapy. This is precisely due to the implication that choices cannot be made by a third party. As the insight evolves, as people make decisions with which they are oriented toward new goals, these decisions tend to be effected through actions driven to the achievement of these new goals.[8]

Thus, from this perspective, the authentic therapeutic process relies, as a motivation, on the impulses for growth and normality that exist in all people. If these impulses are not strong enough to make positive choices possible, it is doubtful that any success in the therapeutic process can be expected.

Here, it is worth highlighting the precautions taken by Rogers to health professionals that can be particularly useful for the practice of FCM.

1. When health professionals feel insecure about themselves, it is better to avoid any kind of interpretation.
2. In any interpretation, it is preferable to use the person's expressions and symbols.
3. It is always better to deal with already expressed attitudes, that is, interpreting unexpressed attitudes is clearly dangerous.
4. There is nothing to be gained by discussing an interpretation. If it is not accepted, its non-acceptance is an important fact. The interpretation must be abandoned.
5. If authentic insight has been achieved, the person will spontaneously see its application in other domains. If this is not the case, health professionals can be confident that it was them, not the person, who achieved the insight.
6. After achieving a significant insight, health professionals must be prepared to observe a temporary relapse. It is important at this point to recognize and accept these feelings and be patient and understanding. This way, the person will soon demonstrate that it was a momentary withdrawal from the struggle involved in developing into maturity.

Likewise, the guidelines provided by Rogers in the event of missing consultation are particularly useful to the practice of FCM. In these situations, according to him, health professionals have two important things to do. The first is to study their notes, especially those referring to the last consultation, and ask oneself the following questions: were the techniques of the forcing type, susceptible to creating resistance? Was there a rather premature interpretation? Did the person face a very difficult choice before being prepared for it? Did they show, through progress, that they were ready to end the follow-up and this new independence was not recognized or accepted? The second thing to do is to facilitate the return as much as possible, at the same time helping subjects to understand that if they choose not to return, that solution will also be accepted by the health professional.

Third point: the three key concepts (or key attitudes) of the person-centered approach: congruence, unconditional positive regard, and empathic understanding

In the book *On Personal Power*,[12] Rogers presents three key concepts (or key attitudes) that must permeate the encounter between people. There are three conditions that must be met in order to achieve the necessary environment to promote the growth and development of the person, whether in the relationship between therapist and person, or between leader and group, teacher and student, administrators and team, that is, in any situation in which personal development is an objective.

The first key concept (or key attitude) consists of authenticity, veracity, or the term that will be preferred by the author: “congruence”.[12,13] This means that, “the more the therapists are themselves in the relationship, not putting on a professional or personal facade, the greater the probability that the person will change and grow in a constructive way.”[12] Through congruence, therapists will be openly experiencing their feelings and attitudes at the time of the consultation.

The term “transparent” connotes this element, “the therapist becomes transparent to the person, the person can clearly see what the therapist is in the relationship, the person does not perceive any blockage on the part of the therapist”.[12] Thus, “there is congruence between what is being experienced at the visceral level, what is present in consciousness and what is expressed to the person”.[12]

What does this concept mean in practical terms? It means that, “when people are suffering or distressed, therapists are able to feel tenderness, compassion or understanding. However, at other times in the therapeutic relationship, one may feel boredom, anger, or even fear of a destructive person”.[12] Thus, “the more self-aware the therapist is — and can accept and express these feelings, whether positive or negative — the more likely they are to be able to help the person”.[12] For Rogers, therefore, it is feelings and attitudes that promote help when expressed, not opinions or judgments about the other person. Opinions and judgments are debatable, but therapists can only be congruent and helpful when expressing their feelings. As therapists experience, reflect, and express what happens to them, they will be able to facilitate the person’s growth and development. It is as if the therapist said: “here I am as I am”.[12] And the person, “discovering that the therapist is allowing himself to be as he is, can also find the same freedom”.[12]

The second key concept (or key attitude) in creating an environment for change is acceptance, concern, or consideration — the “unconditional positive regard.”[12,13] This element of the approach means that, “when therapists are having a positive, accepting attitude toward whatever the person is being at that moment, the likelihood of a therapeutic movement or change occurring increases.”[13]

However, a therapist who is real will often have very different, even negative, feelings toward the person. Therefore, Rogers assures, this should not be considered an imposition, that is, that it is necessary for the therapist to have unconditional positive regard for the person at all times. It is about the fact that “the person’s constructive change is less likely if this element does not occur with some frequency in the relationship”.[12]

The third key concept (or key attitude) of the therapeutic relationship is “empathic understanding”.[12,13] This third element implies the following movement: “the therapist accurately captures the personal feelings and meanings that the person is experiencing and communicates this understanding to the person.”[13] This happens mainly through active and sensitive listening, which “allows therapists to be able to enter the person’s internal world and clarify not only what is conscious but also what lies beneath of the level of consciousness”.[13]

The author demonstrates, through his numerous case reports, that people who seek help change for the better when they are involved in a relationship with a health professional who has these elements. Moreover, that the process of change in the person is a reciprocal of the therapist’s attitudes, that is, as the person “finds the therapist listening with acceptance to their feelings, they become able to listen with acceptance to themselves” — listening to and accepting the anger, the fear, the tenderness, the courage that is being experienced. As people observe therapists appreciating and valuing even the hidden and unpleasant aspects that have been expressed, they experience appreciation and affection for themselves. As therapists are perceived as being real, people are able to let go of facades, to show more openly their inner experience”.[12]

Thus, with Rogers, the focus of the clinical approach shifted from theories to attitudes, that is, to respect, authenticity, interest, acceptance and empathic understanding.

In the book *On Becoming a Person*,[10] he mentions that, at the beginning of his career, he asked himself how he could treat or cure or change a person, however, at that moment, he announced the question in another way: how could he provide a relationship that one could use for their own personal growth?

Another striking feature of his approach is considering the therapist's authority: "it is people themselves who know what they suffer from, which direction to take, which problems are crucial, which experiences have been deeply repressed. I began to understand that, in order to do more than demonstrate my own clairvoyance and wisdom, it was best to let people direct the movement in the therapeutic process."[10]

And, in going through this perspective, he concludes: "I can do no more than try to live by my own interpretation of the present meaning of my experience, and try to give others permission and freedom to develop their own inner freedom so that they can achieve a meaningful interpretation of their own experience".[10]

Regarding the three key concepts (or key attitudes) of PCA, the author considers that the third element, that of empathic understanding, is perhaps the most easily improved.[12] Health professionals can learn to be better listeners, more sensitive, more empathetic, as this is in part a skill as well as an attitude. However, in order to become more authentic and congruent and more attentive and interested in the people they serve, health professionals must change experientially, which is a slower and more complex process.[12]

CONCLUSION

Rogers innovated not only in concepts and perspectives, but also in investigation and research in the field of psychology, being also a pioneer in the application of recording, transcription and analysis methodologies of interviews and consultations. In addition, he always kept in dialogue with his own clinical experience, so that all his books are crossed by case reports, from which his analyses invariably start or with which they are exemplified or concluded — a characteristic that makes so that his books also offer a pleasant and fluid reading, with excerpts or vignettes of cases that help readers at all times, facilitating the understanding of the concepts.

To the reader of Rogers' work, two aspects are increasing. The first is that, as the reading progresses, the growing scope that its perspective takes, from working with children and the updating trend, passing through the focus on the client, on the group, on the team, on the student, until centering on the person, becoming a person, a therapist, a way of being in the world, politics, the formative tendency present in nature, in the universe. The second is that it becomes increasingly clear to the reader that Rogers' concern was not to describe some type of psychotherapeutic technique *per se*, but to outline a posture or an attitude toward the patient, the person, the other, to otherness and, more broadly, to life. In this way, we find, in Rogers' work, the concepts that should guide the therapeutic relationship, which must operate at all times the meeting between doctor and person, thus contributing to the best performance of the four components of the PCCM, particularly for the "intensifying the relationship between person and doctor".

The humanist perspective, by indicating as the axis of its approach the reinforcement of positive aspects and the stimulus to the capacity for regeneration, represents, finally, a counterpoint to the hegemonic biomedical clinic, based on the orientation of the fight against the disease. The perspective of building and improving the humanist clinic is alive through Rogers' work, so that, precisely for this reason, this reference offers an enormous potential for qualifying the FCM clinic.

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CONFLICT OF INTERESTS

Nothing to declare.

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