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Classical conditioning

The process of closely associating a neutral stimulus with one that evokes a reflexive response so that eventually the neutral stimulus alone will evoke the same response.

Classical conditioning is an important concept in the school of psychology known as **behaviorism**, and it forms the basis for some of the techniques used in **behavior therapy**.

Classical conditioning was pioneered by the Russian physiologist **Ivan Pavlov** (1849-1936) in the 1890s in the course of experiments on the digestive systems of dogs (work which won him the Nobel Prize in 1904). Noticing that the dogs salivated at the mere sight of the person who fed them, Pavlov formulated a theory about the relationship between stimuli and responses that he believed could be applied to humans as well as to other animals. He called the dogs' salivation in response to the actual **taste** and **smell** of meat an *unconditioned response* because it occurred through a natural reflex without any prior training (the meat itself was referred to as an *unconditioned stimulus*). A normally neutral act, such as the appearance of a lab assistant in a white coat or the ringing of a bell, could become associated with the appearance of food, thus producing salivation as a *conditioned response* (in response to a *conditioned stimulus*).Pavlov believed that the conditioned reflex had a physiological basis in the creation of new pathways in the cortex of the **brain** by the conditioning process. In further research early in the 20th century, Pavlov found that in order for the **conditioned response** to be maintained, it had to be paired periodically with the unconditioned stimulus or the learned association would be forgotten (a process known as **extinction**). However, it could quickly be relearned if necessary.

In humans, classical conditioning can account for such complex phenomena as a person's emotional reaction to a particular song or perfume based on a past experience with which it is associated. Classical (sometimes called Pavlovian) conditioning is also the basis for many different types of fears or phobias, which can occur through a process called stimulus generalization (a child who has a bad experience with a particular dog may learn to **fear** all dogs). In addition to causing fears, however, classical conditioning can also help eliminate them through a variety of therapeutic techniques. One is systematic **desensitization**, in which an anxiety-producing stimulus is deliberately associated with a positive response, usually relaxation produced through such techniques as deep breathing and progressive muscle relaxation. The opposite result (making a desirable stimulus unpleasant) is obtained through aversion therapy, in which a behavior that a person wants to discontinue—often an addiction, such as alcoholism—is paired with an unpleasant stimulus, such as a nausea-producing drug.

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Client-centered therapy

An approach to counseling and psychotherapy that places much of the responsibility for the treatment process on the patient, with the therapist taking a non-directive role.

Developed in the 1930s by the American psychologist **Carl Rogers**, client-centered therapy—also known as non-directive or Rogerian therapy—departed from the typically formal, detached role of the therapist common to **psychoanalysis** and other forms of treatment. Rogers believed that therapy should take place in the supportive **environment** created by a close personal relationship between client and therapist. Rogers's introduction of the term "client" rather than "patient" expresses his rejection of the traditionally authoritarian relationship between therapist and client and his view of them as equals. The client determines the general direction of therapy, while the therapist seeks to increase the client's insightful self-understanding through informal clarifying questions.

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of client-centered therapy: congruence, unconditional positive regard, and **empathy**. Congruence refers to the therapist's openness and genuineness—the willingness to relate to clients without hiding behind a professional facade. Therapists who function in this way have all their feelings available to them in therapy sessions and may share significant ones with their clients. However, congruence does not mean that therapists disclose their own personal problems to clients in therapy sessions or shift the focus of therapy to themselves in any other way.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging, or giving advice. This creates a nonthreatening context in which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy ("accurate empathetic understanding"). The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. In other systems of therapy, empathy with the client would be considered a preliminary step enabling the therapeutic work to proceed, but in client-centered therapy, it actually constitutes a major portion of the therapeutic work itself. A primary way of conveying this empathy is by active listening that shows careful and perceptive **attention** to what the client is saying. In addition to standard techniques, such as eye contact, that are common to any good listener, client-centered therapists employ a special method called reflection, which consists of paraphrasing and/or summarizing what a client has just said. This technique shows that the therapist is listening carefully and accurately and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally, clients respond by elaborating further on the thoughts they have just expressed.

Two primary goals of client-centered therapy are increased **self-esteem** and greater openness to experience. Some of the related changes that it seeks to foster in clients include increased correspondence between the client's idealized and actual selves; better self-understanding; decreases in defensiveness, **guilt**, and insecurity; more positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur. Beginning in the 1960s, client-centered therapy became allied with the **human potential movement**. Rogers adopted terms such as "person-centered approach" and "way of being" and began to focus on personal growth and **self-actualization**. He also pioneered the use of encounter groups, adapting the **sensitivity training** (T-group) methods developed by **Kurt Lewin** (1890-1947) and other researchers at the National Training Laboratories in 1950s.

While client-centered therapy is considered one of the major therapeutic approaches, along with psychoanalytic and cognitive-behavioral therapy, Rogers's influence is felt in schools of therapy other than his own, and the concepts and methods he developed are drawn on in an eclectic fashion by many different types of counselors and therapists.

CLIENT-CENTERED THERAPY

QUALITIES OF THE THERAPIST

Congruence: therapist's openness to the client

Unconditional positive regard: therapist accepts the client without judgement

Empathy: therapist tries to convey an appreciation and understanding of the client's point of view

GOALS OF THE THERAPY

Increase self-esteem

Expand openness to life experiences.

Further Reading

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Clinical psychology

The application of psychological principles to diagnosing and treating persons with emotional and behavioral problems.

Clinical psychologists apply research findings in the fields of mental and physical health to explain dysfunctional behavior in terms of **normal** processes. The prob-