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1

Person-centred therapy today and tomorrow: vision, challenge and growth

MICK COOPER, MAUREEN O'HARA, PETER F. SCHMID
AND ARTHUR C. BOHART

This chapter discusses:

- A person-centred vision for counselling, psychotherapy and social change
- The key contemporary challenges facing the person-centred approach
- Meeting the challenges through developing the evidence base for person-centred counselling and psychotherapy
- Meeting the challenges through articulating, and developing, the unique contributions of the person-centred approach
- Meeting the challenges through developing our understanding of different client groups; developing our political acumen and links both internationally and with other approaches; using person-centred principles as the basis for integrative theory and practice; and extending person-centred concepts into the sociopolitical realm

Person-centred counselling and psychotherapy offers a radically non-pathologizing, evidence-based, humanistic vision of how to help people heal and grow. It is unique among current therapies in focusing on the potential of all human beings to self-right, actualize themselves, become more fully human and develop their capacities for a deep caring of others. Person-centred therapy offers a major alternative to approaches that – while often helpful and well-meaning – tend to

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see people through the lens of disease, reducing them to their dysfunctional cognitions, conditioned responses or instinctual drives. Of most importance to the person-centred approach is its vision of the nature of the human being and its focus on the power of an empathic, supportive relationship for facilitating personal and social transformation. This goes right back to the very foundations of the approach, where Carl Rogers' outlined the basic conditions of a facilitative therapeutic relationship (see Chapters 2 and 3).

Person-centred therapy has historically has been one of the most influential approaches in the field of psychological therapies. Its founder, Carl Rogers, is still seen as the single most influential psychotherapist by other psychotherapists, even over Freud (Cook, Biyanova, & Coyne, 2009). Some of its tenets, for instance on the importance of the therapeutic relationship, have been widely adopted by other therapeutic approaches and research programmes (see, for instance, Norcross & Lambert, 2011).

Yet, despite the evidence that person-centred therapeutic approaches have levels of effectiveness equivalent to those of other therapies (see Chapter 31), the full vision of the person-centred approach – with its focus on the positive self-determined growth potential of human beings – has, in the current healthcare environment in many countries, come to be overshadowed by approaches that focus on the engineering of how people think, feel and behave (Box 1.1). In an age when human dignity seems to be under assault from a reduction of human beings to the status of objects and mechanisms – and where mental distress is on the rise globally – approaches to health and growth that affirm the human capacity for self-regulation and healing, and that are aligned with the emergent creative impulse in all living systems, would seem to be needed more than ever.

Box 1.1

The person-centred approach within late modernity

In some parts of the world, the person-centred approach appears to be losing ground, outrun by approaches such as cognitive-behavioural therapy (CBT) and psychopharmacology that are framed within an instrumentalist and mechanistic worldview. This can be seen as being consistent with – and reflecting – the cultural crisis of late modernity wherein dimensions of life once understood through the multiple frames of politics, morality, civil society, religion, culture and the arts tend to be squeezed into the shrunken logic of economics and technology. To understand the success of such approaches in the last decades requires that we understand the existential crisis of late twentieth- and early twenty-first-century consumer societies.

Largely as a consequence of the success of twentieth-century science and industrialized capitalism to deliver what once needed communities to provide, the

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predominant sense of ourselves, what Fromm (1955) called our *social character*, has started to lose contact with a deeper flow of human existence, with our connection to each other, and with our dependence upon the natural world. So, in compensation perhaps, most of our attention is on control and manipulation – of ourselves as isolated and vulnerable individuals and of the inevitabilities of illness and death – and on an exploitation of our environment as means to gratify our endlessly manufactured and so insatiable appetites. The emancipatory project of humanistic psychology, especially person-centred approaches, has been to address this alienation, to re-connect people to a universal creative force, and to restore the freedom and dignity of each person to become fully human in relationships.

Neither CBT nor psychopharmacology is necessarily antagonistic to the search for transcendence that animates humanistic approaches. Indeed, many humanistic psychologists, even person-centred therapists, use the empowering and healing potential of both in their work. But whether a psychotherapeutic process is emancipatory or manipulative depends largely on the philosophical, ethical, societal and institutional framework within which it is offered, and it must be admitted that both CBT and medications have become part of a medical industrial complex that is often vastly profitable. The mental health world, then, can be seen as being engaged in its own version of the larger cultural crisis that shows up in the increasingly acrimonious debate between those who see mental health interventions through a mechanistic lens of industrialized medicine, and those who see counselling and psychotherapy as a path to greater capacity for self-determination and wholeness.

Challenges

In many parts of the world, for instance Austria, Eastern Europe, South America and China, the person-centred approach continues to thrive and grow. In other regions, however, person-centred therapists have struggled to maintain and develop their identity and viability, particularly within the contemporary healthcare landscape (Cornforth & Lambers, 2010). In the UK, for example, publicly funded person-centred therapy services are being decommissioned, and members of the person-centred community state that they feel that their profession, orientation and employment are under threat (Cooper, 2011) (for a further discussion, see Chapter 26). In Germany, meanwhile, Hofmeister (2010, p. 7) reports that the person-centred approach is 'gradually and increasingly disappearing from sight' in the field of psychotherapy, the approach being marginalized within academic institutions, and person-centred therapists only being able to be licensed within the system of health insurance companies 'under the accepted labels of "psychodynamic" or "(cognitive) behavior therapy'. Even in Japan, which has an otherwise thriving person-centred

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and person-focusing community, Shimizu (2010) reports pessimism over the future of the person-centred approach, and that young trainee and practising therapists are being attracted towards cognitive-behavioural therapy (CBT).

The rise of the empirically supported therapies movement

These shifting fortunes may to a great extent be attributed to the changing landscape for psychotherapy and counselling services in general. As healthcare costs rise exponentially everywhere, anxious to meet public pressure for value for money, there has been a global movement calling for more accountability in all service sectors. This has driven a rising demand for the so-called empirically supported therapies (ESTs). Healthcare is a highly contentious space, with immense political and economic forces at play. This is particularly true in advanced technological societies such as Northern Europe and Japan, where economic logic, closely coupled with mechanistic science, is the taken-for-granted way of understanding effectiveness.

The basic principle behind the EST movement is that therapeutic practices are considered valid only to the extent that they have been 'proven' to work: through experimental studies (primarily randomized clinical trials [RCTs]), with particular groups of clients, with specific diagnoses (see Chapter 31). This is the viewpoint held by many powerful political organizations, such as England's National Institute for Health and Clinical Excellence, whose recommendations on clinical treatments for specific psychological difficulties has directly informed the commissioning and funding of publicly available therapeutic services and training, most notably through the recent Improving Access to Psychological Therapies programme.

Here, the problem for person-centred therapies is *not* that they have been proved ineffective or inefficient. Rather, in contrast to other orientations such as CBT, there have simply not been enough of the kinds of study that organizations like the National Institute for Health and Clinical Excellence endorse to *prove* their efficacy. And the reason for this touches a principled question: to a great extent, the research methods employed in these studies violate the fundamental beliefs and practices of person-centred theory and practice. An RCT, for instance, requires a categorization of clients into specific diagnostic groupings, random allocation to different 'conditions', the delivery of standardized, 'manualized' therapies, and an analysis of data that reduces clients' lived-experiences down to de-contextualized, de-individualized averages (see Chapter 31 for a further discussion).

Members of the person-centred and counselling communities (see, for example, Cooper, 2008; Rowland, 2007), along with many other psychotherapy researchers and academics (for example, Wampold, 2001; Westen, Novotny, & Thompson-Brenner, 2004), have vigorously challenged the assumptions underlying ESTs. They have highlighted, for instance, the lack of evidence for the existence of discrete psychological 'pathologies', the way in which RCTs can be biased in favour of the researchers' own allegiances, and the overwhelming body of evidence to suggest that it may not be therapeutic orientation that determines the outcome, but such *common*

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factors as the quality of the therapeutic relationship and clients' levels of motivation. Nevertheless, all the evidence indicates that the EST movement is carrying on unabated (Cooper, 2011). It seems unlikely, then, that the challenge of the EST movement will decline in the near future, and the ability of the person-centred movement to respond constructively to it may be a key determinant of its ability to flourish in many regions of the world.

Dilution of person-centred values and practices in integrationism and eclecticism

Although almost all therapeutic approaches refer to person-centred principles – such as empathy, prizing the client's own valuing system, attentiveness, authenticity and non-intrusiveness (mainly without referencing the Rogerian origins of such thinking) – most of them see these characteristic as ingredients that need *to be used* in therapy *in order to* make therapy work. This means that, on the one hand, the person-centred approach is having a major impact on the development of psychotherapy as such; on the other hand, however, this can water down the very gist and essence of the core idea of the person-centred approach, namely that it is engagement within the relationship that *is* the therapy (see Chapter 5 and Part II).

Developments that come from within the approach also present a challenge. There are attempts to combine the person-centred approach with techniques from other orientations, regardless of ethical considerations and reflections on the image of the human being, often in the attitude of 'anything goes' or 'anything that is "positive" helps', or even 'whatever I do for the client is "client-centred"'. But the logic here seems to follow the idea that 'chocolate sauce is fine, fish is fine … so fish with chocolate sauce must be twice as tasty!' Such haphazard, uncritical and unsystematic combinations of theories and practices (Hollanders, 2003) run the risk of reducing the person-centred approach to a *syncretic* mish-mash of practices: a bland, superficial eclecticism. This is not to say that all integrations or hybridizations are theoretically incoherent and clinically ineffective. In fact, a value-based integrative practice is suggested later in the chapter as one possibility for developing the person-centred approach (see also Chapter 17). But the key to these latter forms of integration is that they root themselves in person-centred anthropology and values (see Chapters 5 and 6). The ability to know the difference between an incoherent mash-up and a potentially creative synergy requires critical discernment.

Global social, environmental and economic threat

Alongside challenges from within the therapy world, it should not be forgotten that the twenty-first century will present humanity with challenges that will threaten entire ecosystems and perhaps the survival of civilizations (see Chapter 32). Already there are signs that the constellation of pressures from escalating economic instability, war, famine, population dislocation, global climate change and scarcities of

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energy, food, water and other vital resources – coupled with the disintegration of cultural coherence and continuity – are producing a serious deterioration in mental health on a global scale. By 2020, depression is expected to be the second leading cause of death after heart disease, and most of it goes untreated (O'Hara, 2010). Population-scale mental distress may need approaches to care that de-emphasize individual counselling in whatever form in favour of health promotion, personal empowerment, re-personalization, medication and capacity-building within communities to train local people to care for people where they live.

Meeting the challenges

How, then, have – and can – members of the person-centred community meet these challenges? First and foremost, perhaps, person-centred practitioners, theoreticians and researchers need to remember and recall the strengths inherent in their approach to fellow human beings. From its foundation, the person-centred approach has been an approach that leaves the power with the client (whence it is *client-centred*) and regards individuals as people fully capable of living their own lives, when encountered and supported by another person (whence it is *person-centred*). It regards psychotherapy as an emancipatory practice, and as such it is primarily concerned with people becoming more fully human in their own way.

The person-centred approach trusts in facilitating this process of personality development through a dialogical relationship (see Chapters 2 and 5). Among the strengths of the approach are its anthropology (see Chapter 5), its ethically and empirically based exploration of the nature of the human being (see Chapters 28 and 31), its openness to non-orthodoxy, its commitment to development and thus research (see below), its principled scepticism towards categorizations (traditional diagnostic systems) and dogmatism (schoolism), and – intrinsically connected – its attentiveness to societal and political processes (see Chapter 32). Person-centred approach thinkers have also been at the forefront of establishing psychotherapy science as a discipline in its own right (for example, person-centred psychotherapy science as an independent study at the Carl Rogers Institute of the Sigmund Freud University in Vienna) instead of seeing it as an appendix to psychiatry or psychology.

Consolidating and developing the person-centred evidence base

One of the main legacies of Carl Rogers to the field of psychotherapy was rigorous empirical research. Although the methods of Rogers and the person-centred approach in conceptualizing – and carrying out research – can be very different from those of the mainstream (see below and Chapter 31), research has been willing to meet the challenge of the current trend to prioritize ESTs.

In this respect, one emerging response to the call for ESTs has been to develop, or bring to the fore, the evidence that already exists for person-centred therapies. Robert Elliott has for several years advocated and led such a strategy (Elliott, 2002a,

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2002b; Elliott & Freire, 2008, 2010; Elliott & Greenberg, 2002; see also Chapter 31), and in the closely related field of the experiential therapies (see, for example, Elliott, Greenberg, & Lietaer, 2004; Greenberg & Dompierre, 1981; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), it has proved relatively successful and has led to the establishment of emotion-focused therapy, also known as process-experiential therapy, as an evidence-based treatment for depression by the American Psychological Association (see www.div12.org/treatments).

With such a strategy in mind, at the 2008 conference of the World Association for Person Centered and Experiential Psychotherapy and Counseling (WAPCEPC) in Norwich, a Task Force was set up to 'review the evidence-base for PCE [person-centred and experiential] practice, to disseminate the results of this investigation, and also to identify key areas in which the evidence base for PCE practice needs to be developed.' The product of this enterprise, *Person-centred and Experiential Therapies Work: A Review of the Research on Counseling, Psychotherapy and Related Practices*, was published in 2010 (Cooper, Watson, & Hölldampf, 2010b), and provides the first comprehensive summary of evidence for PCE approaches, as well as a review of person-centred methods of research and person-centred measures.

Such a review of the research is in itself, however, unlikely to have much of an impact on EST-oriented commissioning and funding bodies. For although much RCT research can be reviewed and analysed to point towards the effectiveness of person-centred practice (see Chapter 31), it is often not of the 'right type', lacking a focus on specific clinical disorders, with poorly defined 'interventions' and inadequate methodological rigour. On this basis, the editors of *Person-centered and Experiential Therapies Work* (Cooper, Watson, & Hölldampf, 2010a) argue that there is a need for members of the person-centred community to adopt a pragmatic stance, writing that:

> a key priority for research in the PCE field – both psychotherapeutic and non-psychotherapeutic – must be to conduct randomised controlled trials of a type that have the potential to impact upon policy-makers (see, for example, Watson et al. (2003) or King et al. (2000)). Such trials will need to:
>
> - Focus on a specific group of clients, such as clients meeting criteria for generalised anxiety disorder or major depression;
> - Be conducted and written-up according to standardised recommendations for high quality trials (see Moher, Schulz, & Altman, 2001);
> - Use a standardised PCE intervention.

In developing the evidence base for person-centred therapies, however, it would seem important not just to focus on RCT methods, and Cooper et al. (2010a) go on to recommend several other strategies through which the evidence base might be enhanced:

- Systematically drawing together research findings in the person-centred field through quantitative (for example, Bratton, Ray, Rhine, & Jones, 2005) and qualitative (for example, Timulak & Creaner, 2010) *meta-analyses*.

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- Conducting *process research* with individual cases or sets of cases to help identify the helpful (and unhelpful) aspects of person-centred therapy (see Watson, Greenberg, & Lietaer, 2010).
- Qualitative and quantitative explorations of phenomena that emerge from a person-centred understanding of human being and change, such as *presence* (see Chapters 5 and 14) and *relational depth* (see Knox, Murphy, Wiggins, & Cooper, 2013).
- Developing measures, like the Authenticity Scale (Wood, Linley, Maltby, Baliousis, & Joseph, 2008) and the Strathclyde Inventory (Freire, Cooper, & Elliott, 2007), which can directly assess the outcomes and processes associated with person-centred theory and practice.
- Using research findings to help improve the effectiveness of, and/or client experience within, person-centred therapy (for example, Greenberg, 1979, 1980).
- Developing methods of research that are specifically consistent with person-centred theory and practice, such as phenomenological inquiry (see Wilkins, 2010).
- Developing and conducting case studies (see McLeod, 2010).

In addition, a very valuable emerging strategy for the person-centred field may be:

- Collecting, collating and reporting practice-based evidence, using tools such as the CORE-OM (Barkham et al., 2001), which can indicate the extent to which person-centred practice, in 'real-world' settings, is associated with reductions in psychological distress (for an excellent example, see Gibbard & Hanley, 2008).

Cooper et al. (2010a) also give concrete suggestions for how each member of the person-centred community can contribute to developing the evidence base, making the point that there is no one 'out there' – or even within the community – that can do this work for us: that it is a responsibility for us all (Box 1.2).

Box 1.2

Developing the evidence base for person-centred therapy: what you can do

Academics/researchers/research students

- In choosing a subject to research, always consider the likely policy impact – ask yourself, 'Is this going to contribute to the development of the person-centred and experiential (PCE) approach?'
- Design, and apply for funding for, a pilot randomised controlled trial of PCE therapies with a particular client group.
- Set up, help to collect, and/or analyse person-centred PBE [practice-based evidence].
- Conduct a meta-analysis of PCE therapy with a particular client group.

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- Develop a study which can help to validate a PCE outcome measure.
- Develop an outcome or process measure that assesses a particular aspect of PCE theory or practice.
- Consider how you can use research to help you develop PCE practices.
- Publish a case study of PCE practice.
- Engage in PCE research.
- Develop rigorous and systematic critiques of positivistic research methods.

Practitioners and non-research students

- Link up with others in the field who are interested in developing evidence for the approach (for instance, the British Association for the Person-Centred Approach (BAPCA) now has a Research Group, email: research@bapca.org.uk [see also www.bapca.org.uk/research.html]), and see how you might get involved.
- Evaluate your work using outcome measures (such as CORE-OM) at pre- and post-counselling, or process measures like the Experiencing Scale (Klein, Mathieu-Coughlan, Gendlin, & Kiesler, 1969).
- Familiarise yourself with the research findings for PCE and other therapies, as well as the critiques of 'evidence-based' assumptions (see, for instance, Cooper, 2008; Cooper, Watson, & Hölldampf, 2010b; Elliott, et al., 2004).
- Consider enrolling for a research (MA/MSc/PhD) programme.
- Contact PCE-oriented researchers/academic to see how you can collaborate on research.
- Consider writing a case study (see McLeod, 2010).

(Cooper et al., 2010a, p. 294)

The drive to consolidate, articulate and develop the person-centred evidence base may seem like a primarily defensive measure, designed to ensure the long-term survival of person-centred therapy. Yet to the extent that research, as identified above, can help the person-centred community to refine, develop and enhance its practice and theory (as an excellent example, see Geller's work on presence in Chapter 14), it also provides an opportunity for growth.

One emerging finding from studies of clients' experiences of therapy, for instance, has been that feeling genuinely *cared for* is a key element of successful therapy (McMillan & McLeod, 2006) and it may be that, in the coming years, we will come to see *care* as a better articulation of a necessary and sufficient condition for therapeutic personality change than *unconditional positive regard*. In this respect, the current research agenda has the possibility of helping the person-centred approach go back to – and build on – its roots in the 1940s and 50s: as a vibrant and inquiring community of practitioners, researchers and academics who draw extensively from the research evidence – indeed who, at their time, led the psycho-

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therapy research field (McLeod, 2002). This attitude towards research is summed up by Carl Rogers himself (1986, cited in Cain, 2010, p. 42), stating:

> There is only one way in which a person-centred approach can avoid becoming narrow, dogmatic and restrictive. That is through studies – simultaneously hard-headed and tender-minded – which open new vistas, bring new insights, challenge our hypotheses, enrich our theory, expand our knowledge, and involve us more deeply in an understanding of the phenomena of human change.

Articulating, and developing, the particular contributions of the person-centred approach

With current movements towards a greater integration of therapies – as well as the counter-movement towards ESTs – the future of the person-centred approach may also be dependent on its ability to articulate, and emphasize, its particular contribution to the wider therapeutic field. If moves towards a greater integrationism are considered inevitable, however, or even embraced (see Chapter 17 and below), another way of phrasing this question might be to ask: 'How can we ensure that the key values and practices of person-centred therapy become embedded, in meaningful and significant ways, in a broader landscape of growing integrative and eclectic practices?' Moreover, how can we work towards developing, and building upon, these particular contributions, so that they continue to remain a figural, vibrant and thriving element of this wider therapeutic field?

In recent years, numerous members of the person-centred community have been working on articulating what these particular contributions may be, and each of these can serve as valuable foundations for future work.

A humanizing commitment

For many of us, the heart of a person-centred approach is the commitment to engaging with clients in 'deeply valuing and respectful ways' (Cooper, 2007, p. 11). Therapeutic techniques, strategies and theories may all have their place in an integrative landscape, but a person-centred perspective keeps to the fore the ethical responsibility to engage with each client as a growth-oriented, subjectively experiencing Other (see Chapter 28), and not as a mechanism, thing or collection of bit-parts that requires external 'fixing'. Such a basic, humanizing, stance has acted as the basis for several important person-centred contributions in recent years, such as Warner's reconceptualization of psycho-'pathology' as *difficult processes* (see Chapter 23), and has the potential to underpin many more humanizing ways of understanding clients and the therapeutic process.

Deep relating

The concept of a *therapeutic*, or *working*, alliance has become common currency across the psychotherapies (see, for instance, Hovarth, Del Re, Fluckinger, & Symonds, 2011), but where person-centred (and again related humanistic and existential)

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