'A call to arms for person-centred therapists'

It's time to champion our philosophy and challenge the dominance of medical model pathology, says **Louise Wilson**

Person-centred therapy sits on the lowest rung in the hierarchy of therapeutic modalities. In my own experience, and that of many colleagues, the approach is broadly viewed within the profession as insufficient and passive, and therefore inferior in comparison with other therapies where the counsellor takes a more leading role. The power that Carl Rogers invested so fully in the client has been steadily drifting back towards the therapist. It is not surprising that the current psychological establishment seeks to maintain and perpetuate this situation – person-centred therapy is less threatening if it can be perceived as deficient. This is a serious existential threat to the approach, and we must fight for our modality and demonstrate the power and effectiveness of person-centred therapy, otherwise it will diminish and fade, until it's of historical interest only.

The therapeutic landscape looks very different today than in 1951, when Rogers first outlined his detailed theory of constructive personality change. At that time the transfer of the structural power from the 'expert' therapist to the individual seeking help was a radical proposition, and denounced as dangerous or foolish by the psychiatric community. To rely on the subjective experiencing of the person would lead to the creation of psychopaths as individuals could not be trusted to find their own solutions or be responsible for their own healing. The conversation regarding person-centred therapy has changed dramatically during the intervening years, and what was previously seen as a serious threat to the psychological establishment is now frequently dismissed as what Wilkins describes as 'psychotherapy lite' or 'therapy for the worried well'.[1] The stereotype of the person-centred therapist is someone who just listens and repeats back what the individual has said – inadequate for those with serious psychological problems. From powerful to passive, the view of person-centred therapy has transformed from being too much to not being enough.

The current landscape is heavily dominated by an omnipotent medical model based on the diagnostic treatment of symptoms. The juggernaut of behavioural therapies, in particular CBT, is prevalent, particularly in the health service. The three 'core' conditions of unconditional positive regard, empathy and congruence have been simplified and adapted as a base by other modalities within their own frameworks, and the person-centred approach has become diminished and devalued in the process. Many therapists and mental health workers will say they work from a person-centred base but also incorporate other modalities or adapt their way of working to suit the client.

Perhaps what they really mean is that they have absorbed something of the three core conditions into their practice, as a method of listening without embracing the political philosophy of the approach formulated by the six conditions as a whole. The robust and intricate theory formulated by Rogers has been reduced to the core conditions, while the remaining three conditions required for constructive personality change and the 19 propositions outlining personality theory (detailing why non-directivity is so important) have faded from significance, alongside the power of the individual that was so central to Rogerian philosophy.

The implicit understanding is that person-centred therapy is acceptable as a foundation but not enough without other 'expert' strategies and techniques, dovetailing neatly with a dominant medical model, where current focus is firmly on the brain and cognitive functioning, often coupled with medication supplied by a hugely profitable pharmaceutical industry. Individuals are frequently diagnosed with generic psychological conditions – diagnoses usually based on symptoms without taking into account the wider personal, social and political context that has contributed to or caused the distress.

The trouble with labels

Anti-pathology sentiment is long established and well documented. Contemporary websites such as Mad in America, Drop the Disorder, the Hearing Voices Network and ERNI (Emotions are not illnesses) are growing momentum, with some psychiatrists now questioning the validity of psychiatric diagnosis. Allen Frances, psychiatrist and former Chair of the *DSM-IV* Task Force, observed that, 'Mental illness is terribly misleading because the "mental disorders" we diagnose are no more than descriptions of what clinicians observe people do or say, not at all well-established diseases.'[2] Psychiatric disorders are not created from a medical perspective but from the cultural, socio-economic, religious and political context at the time of diagnosis. Homosexuality was listed as a mental disorder in the 1968 *DSM*, only to be replaced with 'sexual orientation disturbance' in 1973 before being completely omitted in the 1987 edition.

Not only are diagnostic labels subject to change depending on the context, but they can also be extremely harmful to the person being labelled. Of course, many individuals experience relief on receiving a diagnosis, usually because it normalises their experience, gives them some sort of explanation and can provide access to services. A diagnosis can provide greater acceptance within a society where the uniqueness of human experience must be defined, categorised and measured. Diagnosis can also be limiting, and individuals may be restricted by the label and feel disempowered, the focus firmly on managing the symptoms without fully exploring the cause and utilising inner resources to bring about more significant personal change.

Labels are generic and not unique. Furthermore, they remove the premise of the client as expert and agent of their own experience, and place the locus of evaluation externally with psychiatrists and other clinicians. The pathological nature of the medical model is contrary to the psychological view given by Rogers, where therapy itself is the diagnosis 'and this diagnosis is a process which goes on in the experience of the client rather than in the intellect of the therapist'.[3] I have worked with many individuals who experienced initial comfort from a diagnosis, only to grow despondent and frustrated by the limitations over time. They believed they were unable to alter aspects of themselves only to find that they did indeed have the inner resources for profound change and growth. Diagnostics are unlikely to truly help someone congruently understand their self-concept.

Towards growth

The stance of Rogers is phenomenological and places each individual at the centre of their own unique experience. Each individual organism has an actualising tendency – a propensity to move towards growth. Destructive experiences can damage the actualising tendency and lead to introjected conditions of worth – values absorbed from significant others. A false self-structure develops, which is in conflict with the organismic self, and this can lead to psychological disturbance or incongruence. Person-centred therapy helps the individual become aware of discrepancies in the self-structure, and it is this awareness of their own experiencing that leads to changes in attitudes and behaviours, and alleviates psychological distress. The six conditions provided by the therapist facilitate such growth. Merry argues that the actualising tendency drives the natural process of change, and the content of this varies according to the needs of each unique individual.[4]

To direct the client in any way is therefore counter-therapeutic and disrupts the natural process. As each individual is unique, direction *must* come from the client, not the therapist. This unique quality renders diagnosis irrelevant, as the latter seeks to generalise and categorise psychological disturbance. The person-centred therapist supports and liberates the individual to access their own personal power in order to trust their own valuing system.

Natiello argues that client empowerment and self-esteem are seriously undermined by dependency on an expert therapist for growth and healing, where therapy is something done to the client by the therapist.[5] The absorption of the 'core' conditions into other modalities has diluted the power impact in the approach and transferred it back to the 'expert'. Furthermore, this absorption is limited to three of the attitudes, without the relational whole of the six conditions, which form the foundation of the philosophy. In general terms all therapeutic frameworks are trying to activate resources within the client so they can help themselves. However, by placing so much trust in the inner resources of the client, person-centred therapy gives more power to the individual than any other modality. Perhaps this is challenging to therapists who prefer a position of power, and therefore take a more leading role within the therapeutic relationship.

From a person-centred perspective, self-exploration and healing are a subjective experience, not easily articulated and put into neat boxes, not always conveniently quantified. However, Rogers was clear in defining the process of therapy. His extensive collection of filmed material provides empirical evidence of the approach, while his writing demonstrates the complex philosophy underpinning the theory. So why has the need to explain, champion and defend the approach become so problematic? Why is it so difficult to articulate just how dynamic, transformative and active the process can be? This is due, at least in some part, to a cultural narrative where value is placed on quantitative measurement, competencies and outcomes rather than subjective experience.

The therapist use of self is a crucial part of the person-centred approach in comparison with the majority of other modalities, which have more of a generic roadmap for what they are doing. Contrary to the belief that the person-centred approach is passive, these are the reasons that it is in fact dynamic, and the non-directive nature of the approach can be challenging. Tolan compared this to a rollercoaster, both exhilarating and scary – the therapist is not in control and cannot play safe and drive the rollercoaster as the actualising tendency cannot be steered.[6] Rogers was exceptionally courageous and radical in trusting the client and trusting himself to bring about change without the safety net of diagnosis and techniques. However, this does not sit well in a landscape that is controlled and measured, where the messiness of human relationships and experience is reduced to statistics. Person-centred is not evidence-based in the same way as other modalities and therefore devalued.

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Efficacy

Measuring efficacy in a therapeutic context is controversial and is particularly problematic from a person-centred perspective. As Macran et al conclude: 'Phenomenologically, it is futile to apply objectivity to something which is subjective by nature. The only true source of therapeutic impact is the experience of the client. However, most outcome research remains (implicitly) dominated by the medical model.'[7] Randomised control trials (RCTs) are the leading form of research, and generally suggest CBT is the most 'effective' modality. However, this is not without challenge, and a study from the University of Gissen concluded that only 17% of RCTs were of 'high quality' due to the high incidence of researcher bias.[8] Research funding can also be political and overwhelmingly directed to quantitative research, and rarely includes qualitative or autoethnographic material.

The reliable data that are available consistently show what is known as the 'dodo bird' verdict, whereby all therapies are broadly equivalent in effectiveness. More than 100 meta-analyses show a consistent, significant correlation between the therapeutic relationship and successful outcomes.[9] From a person-centred perspective, it is the six conditions that are the most effective ingredient in all therapeutic work regardless of modality. There is much agreement in therapeutic circles about the importance of the relationship and being 'person-led'. However, person-centred therapy is the only modality whereby therapist immersion in the world of the client is the sole activator – one human being in relationship with another without the need for ▶

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interpretation or a 'therapist toolkit'. It is frustrating that the quantitative nature of research and outcomes rarely reflects the profound and transformative nature of the person-centred approach.

It is small wonder that we have been left fighting for survival in such a hostile environment. For some, person-centred therapy appears to be mostly palatable when combined with other modalities, either as a base within integrative therapy or repackaged within pluralism. This is philosophically paradoxical - the individual cannot be the expert until the therapist decides otherwise. Of course clients may seek out strategies or techniques. Bombarded with information on how to manage 'conditions' or 'disorders', it is entirely unsurprising that clients would make such requests given the current narrative around mental health. The medical model itself is a pervasive and powerful condition of worth.

It is clear why person-centred therapy is viewed as insufficient in isolation. However, not only is person-centred therapy sufficient, but it is also essential if we are to break free from medical model hegemony and place the power back with the individual. From a neoliberal perspective, the medical model serves the dominant political power well. It's far easier to internalise the problem than to examine the shortcomings of a society where inequality, poverty and the demands of capitalist working conditions provide their own potent conditions of worth. Employee assistance programmes are a good example of ensuring that people are fit for work and productive - short-term therapy to teach those seeking help how to manage their distress without too much exploration of the underlying causes. The pressure for cost-effective therapy will be even greater as online self-help grows and the economic crisis worsens. Undoubtedly the number of disorders will swell in a post-COVID world ('COVID-19 anxiety syndrome' has already appeared).

Person-centred therapy appears to thrive in the private sector where there is more individual choice for those with the means available, and where longer-term work is possible. Unfortunately there is limited research or information demonstrating why this is the case.

Counselling courses within universities are generally viewed as being superior due to their scholarly status. Training has become increasingly academic, competency-based and focused more on 'doing' than 'being'. Learning has become less experiential and creative and more stratified, target driven and risk averse. Universities can be viewed as another condition of worth and therefore not always conducive with person-centred growing and being. Furthermore, such courses are costly, often require degree-level qualifications on entry and are therefore restrictive and elitist. Therapists who trained with Rogers have retired or passed away. The person-centred community is shrinking with every passing year while, paradoxically, aspects of the three core conditions thrive and flourish elsewhere.

Counsellors often work alone in private practice or as part of a small group within an organisation, and this fragmentation can make it difficult to connect and mobilise. However, social media, blogging, video streaming and other channels of communication enabled by the digital revolution can provide many opportunities to network, communicate and find creative ways to promote the approach. Training courses could go further in examining the political context surrounding the decline of person-centred therapy and exploring the reasons for the decreasing status of the approach. They could also do more to promote just how powerful it can be and why this is particularly relevant in a landscape where interpretation and diagnosis reign supreme.

The truth is that Rogers remains a radical and political threat to the current psychological establishment, and the central criticism of person-centred therapy remains the same in 2023 as it was in 1951 - it gives the client too much personal power.

The person-centred approach is theoretically and experientially sound, there is no need to redefine or expand person-centred therapy, it is powerful, political and relevant as it stands.

A call to arms for person-centred therapists is essential. We must raise our voices, champion our philosophy and challenge the dominance of medical model pathology, or we run the risk of becoming a historical footnote, relegated to the archives of therapeutic antiquity. ■

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