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RESEARCH

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This chapter discusses:

- What Does Positivist Outcome Research Tell Us about PCE Therapy?
- Anatomy of a Number: A Deconstruction of Positivist Therapy Research
- Mixed Model Person-Centred-Experiential Therapy Research: Render Unto Caesar
- Promising possibilities for PCE therapy research

Is person-centred-experiential (PCE) research possible? In the early 1960s Carl Rogers gave up both academia and the practice of scientific research and spent the rest of his life engaging in action-oriented pursuits. In retrospect, some (e.g., Lietaer, 1990) have argued that this was a mistake of historical proportions, and accounts in large part for the current beleaguered status of Person-Centred Therapy. Regardless, sometime about 1990, PCE therapists, woke up to the fact that they were being systematically and progressively excluded from training and health care venues throughout the world and needed to do something. Re-engaging in research was put forward as a key proposed solution, especially by those working in Europe or in the experiential part of the tradition (e.g., Elliott, 2002; Greenberg, Elliott & Lietaer, 1994; Lietaer, 1990; Sachse, 2004).

In fact, a veritable profusion of research on person-centred and closely related therapies has occurred over the past 20 years, paralleled by the rapid emergence and acceptance of qualitative research during the same time period.

However, in this rush forward, the issue of the consistency of the emerging research literature with PCE principles has often been overlooked. Much of the recent spate of research has been quantitative and positivistic in nature (i.e., based on assumptions of objectivity and the search for definitive knowledge), in some cases using randomized clinical trial designs, typically viewed as the epitome of rigid scientism by person-centred followers, post-modernists and humanists in general (Bohart, O'Hara & Leitner, 1998). In fact, the body of so-called positivistic therapy research has been surprisingly supportive of person-centred and related approaches, in spite of the deck being stacked against them in multiple ways. Nevertheless, the ethical-philosophical issue remains: Is it acceptable for political purposes to make use of research whose principles are antithetical to PCE Therapy, in order to fend off unfair attacks? More fundamentally, what is it about positivist research that might be anti-person-centred? Is a science based on PCE principles possible? And, if so, what might it look like? These are some of the questions I will try to answer in this chapter.

What Does Positivist Outcome Research Tell Us about PCE Therapy?

Ironically, systematic, quantitative outcome has a person-centred pedigree: The first controlled study of the outcome of psychotherapy was reported by Rogers and Dymond (1954), although the features of modern randomized clinical trial design

evolved later: psychiatric diagnosis, standardized symptom measures, placebo control groups, treatment manuals, complex statistical analyses and so on. (By contrast, the Rogers and Dymond study relied heavily on individualized and projective measures, used a general outpatient sample, was not completely randomized, and used primitive statistics.)

General effects of humanistic/experiential therapies

Over the past 50-plus years, PCE therapies have been the subject of almost 200 studies reporting pre-to-posttherapy results, including some 60 controlled studies comparing one of these therapies to an untreated control group, and 100 studies comparing one of these therapies to some other kind of therapy (Elliott & Freire, 2008, 2010). My colleagues and I used meta-analysis methods to statistically combine the results of these studies, from which the following conclusions can be drawn (Elliott & Freire, 2008, 2010; Elliott et al., 2003):

1. Clients who participate in PCE therapies show large amounts of change over time, with an average effect size of about 1.0 standard deviation (sd) units, which is considered by social scientists to be a very large effect, many times larger than effects typically found for common medical procedures or medications. In other words, on average, PCE therapies make a big difference for clients. Furthermore, this is particularly true for general symptom measures.
2. Post-therapy gains in PCE therapies are stable: they are maintained over early and late follow-up periods. This stability of post-therapy benefit is consistent with the PCE philosophy of enhancing client self-determination and empowerment, indicating that clients continue to develop on their own after they have left therapy.
3. In controlled studies, clients who participate in PCE therapies typically show substantially more change than comparable untreated clients (mean difference about 0.8 sd). These studies show that there is a causal relationship between PCE therapy and client change; in person-centred terms, we can say that clients use PCE to cause themselves to change. In roughly half of the studies clients were assigned randomly to therapy vs no-therapy (or waitlist), making these “Randomized Clinical Trials” (RCTs) and providing a stronger level of evidence (mean difference also about 0.8 sd).
4. In studies comparing active treatments, clients in PCE therapies show gains that are equivalent to those in clients seen in the other therapies (mean overall difference of about 0.0 sd, the same value for both randomized and nonrandomized studies).
5. On the other hand, PCE therapies might be trivially worse than CBT: The whole entire sample of PCE therapies were compared to CBT, there was a small but statistically significant advantage to CBT (mean difference about 0.2 sd).
6. However, when clients seen in “pure” Person-centred therapy (PCT) were compared to clients seen in cognitive-behavioural therapy, the results were still equivalent (mean difference -.09 sd, the same value for both randomized and nonrandomized studies).

7. Interestingly, PCE therapies labeled by researchers as either “supportive” or “nondirective” did less well than CBT (-0.35 sd). In most cases, these were studies done by CBT researchers using non bona fide versions of PCE therapy, explicitly labelled as “controls”. This appears to be the source of small apparent general advantage for CBT over PCE therapies.

Effects of Person-Centred Therapy

Let's take a look at the subsample of pure PCT studies, that is, studies emphasizing the therapist facilitative conditions without additions or limitations to that. As Table 1 indicates, the results of a more focused analysis of the 65 studies of pure PCT are generally very comparable to those reported for the larger meta-analysis. First, the overall pre-to-post effect is also quite large and of the same order (mean ES: .97). Second, the effects are similar across time, from immediate post therapy (mean ES: .97) through early follow-up (less than a year; mean ES: .91), to late follow-up (a year or longer: mean ES: 1.02). Third, in 20 studies comparing PCT to clients receiving no treatment, the effects were again large and comparable to the larger study (mean difference in pre-post ES between treated and untreated groups: .69). Fourth, in 43 studies comparing clients seen in PCT to clients receiving nonPCE therapies, there was essentially no difference: a mean difference in pre-post ES of +.02. This value is close enough to zero as to indicate that PCT is equivalent in effectiveness to nonPCE therapies.

[insert table 1 about here]

However, we are not yet done with the story, because in the current political situation, it is commonly believed that cognitive-behavioural therapies (CBT) are more effective than PCT. For example, in the UK the current NICE guidelines for depression say that CBT should be offered first to clients and then if they refuse this they can be told about that they could receive person-centred counselling but that the evidence for it is weak (National Collaborating Centre for Mental Health, 2009). It is therefore necessary to look more closely at the 22 studies involving direct PCT-CBT comparisons. As Table 1 indicates, the average difference in amount of pre-post change in these studies is -.09 sd, a very small effect in favour of CBT. This means that CBT *might* be very slightly more effective than PCT, but that this can be regarded as trivial for practical purposes. In other words, for any given situation, characteristics of the client, therapist and their emerging relationship will vastly overshadow any almost undetectable difference.

Furthermore, the role of researcher allegiance has not yet been considered. This is the well-established finding that researchers comparing active therapies tend to find results that accord with their theoretical beliefs (e.g., Luborsky et al., 1999). In the larger meta-analysis from which the PCT vs. CBT studies are drawn, there was a strong and statistically significant allegiance effect, in the form of a correlation of -.49, indicating that researchers of either persuasion tend to find what they expect. Interestingly, in this sample of pure PCT studies, there is no researcher allegiance effect (the correlation is +.16), probably because the so-called “nondirective-supportive” therapy studies have been removed here. This is fortunate, because only one of the 22 PCT vs. CBT studies was carried out by a supporter of PCT (Teusch,

Böhme, & Gastpar., 1997), while 11 were carried out by CBT advocates and 10 by neutral parties.

What this all means is that when people claim that CBT is more effective than humanistic therapies or counselling, they are not talking about PCT but rather a caricature in the form of so-called “nondirective/supportive” therapies, which are typically rendered less effective by being restricted in terms of time or content and labelled as “control” conditions. One obvious moral that might be drawn is that PCT researchers should do their own research in order to make sure that their approach is fairly represented!

Anatomy of a Number: A Deconstruction of Positivist Therapy Research

In the previous section, I reported that the average difference in client change in PCT vs CBT was $-.09$ in favour of CBT. But what does this number mean? Where does it come from? What does this have to do with the client’s lived experience?

In positivist therapy research, it all starts with the client sitting down to fill out a standardized, quantitative psychological measurement instrument, such as the CORE Outcome Measure (CORE-OM), a widely used measure of client psychological distress (Barkham et al., 2001). (See Box 1.) From a positivist point of view, these responses are just observable behaviours that psychometric research has shown to be related to other responses on the same and different instruments. For example, the feeling alone item tends across people to go up and down together with the rest of the items on the CORE OM (“inter-item reliability”), and, in the absence of therapy, tends to be relatively consistent over a few weeks or a month (“test-retest reliability”). In other studies, it also correlates with other distress measures, like the Beck Depression Inventory (Beck & Steer, 1988; this is called “convergent validity”) and does not correlate too much with nuisance variables like reading ability or a tendency to tell people what you think they want to hear (“discriminant validity”). In addition, the CORE-OM has high measure utility, because it is easy to give to clients to complete on their own time and doesn’t take long to score, thus being perfect for bureaucratic purposes. In addition, clients generally find it useful to complete, because it helps them symbolize their experience and gives them a sense of having their progress tracked over the course of therapy (“clinical utility”).

[Insert Box 1 about here]

Because these conditions are reasonably met for the CORE-OM, researchers believe they can confidently relate this item (along with others like it) to abstract psychological concepts like psychological distress severity. Thus, Eilidh’s (the client in Box 1) ratings of all 34 items are averaged together at before therapy, say, for a mean score of 1.89, which indicates a moderate level of clinical distress, and also at the end of therapy, say, for a mean score of .74, which indicates only minor or subclinical distress, amounting to what is considered to be a substantial and statistically reliable improvement (in this case, 1.15).

Next, the researcher averages together the pre- and post-therapy scores of the whole collection of depressed clients receiving PCT, and calculates a mean and standard deviation for each set, obtaining, for example, a pre-therapy average (mean) of 1.77 (standard deviation: .39) and a corresponding post-therapy value of .98 (sd: .61). In

order to determine how much this amounts to, the researcher then finds the difference between pre and post-therapy group means (here, .79) and converts this difference score into a common metric or ruler by dividing it by the “pooled standard deviation” (a special kind of average of the two standard deviations, in this case, .51); the resulting value is referred to as a *pre-post effect size* (here, 1.56 sd units, a very large value). The same process is followed for all five outcome measures, resulting in an average pre-post effect size of, say, 1.13 sd units (in our example, some of the other instruments, like the experiential processing measure, have much smaller effects than the CORE-OM).

Because this is a comparative treatment RCT conducted by a CBT therapy advocate, there is also another group of clients who have been given 16 sessions of CBT focused on depression. For a variety of reasons, these clients show slightly larger pre-post effects across the five outcome measures, say 1.22 sd. These reasons are likely to include: the therapists are a bit more closely supervised; the CBT therapists are slightly more comfortable working in a research context; some of their clients like the structure; and the therapists “teach to the test”, signalling implicitly to their clients how they are expected to respond at post-therapy. The comparative effect size in our example is thus just slightly (but not significantly) -.09 in favor of CBT Therapy, the value reported earlier in the meta-analysis of Person-Centred Therapy vs. CBT.

But, again, what does this mean? -.09 is an extremely abstract number, from which all specific references like characteristics of client and therapist or the way in which PCE Therapy or the other therapy were carried out, or even the type of outcome measure etc. have been removed. In other words, all but the most general meaning has been stripped from this number. All we know is that the clients in the PCT feel about the same amount of improvement as the clients in CBT. This has very little nothing to do with Eilidh’s lived experience anymore; her idiosyncratic inner valuing process is ignored; and there is no way of determining its authenticity. In other words, it fails the fundamental PCE principles of contact, empathy, acceptance and genuineness.

However, it is politically a very useful number, because it can be used to persuade professional bodies and government officials that PCE Therapy is a valid and effective treatment, so that they will allow PCE Therapy training to continue and perhaps even mandate government health service provision or health insurance payment for PCE Therapy. So, such numbers are valuable, and probably even essential, for PCE Therapy to continue to survive. (This is an example of “political validity”.) But there is nothing person-centred about this number; in fact, it fundamentally violates person-centredness. So what is to be done about the necessity of such numbers? If we remain ideologically pure, we risk passing out of existence, thus depriving clients of a unique way of working with them. But if these kinds of numbers and the ends-justify-the-means logic that go with them are all the further we go as researchers, then we will have totally sold out ourselves and our clients for a positivist golden calf. Surely we can do better than this!

Mixed Model Person-Centred-Experiential Therapy Research: Render Unto Caesar

It seems to me that there is really only one sensible way forward: To simultaneously carry out *both* political-positivist and person-centred research, to render politically

expedient quantitative data to the government and professional bodies (“Caesar”), while at the same time carrying out (even in the same study) research that completely honours the client and person-centred principles (Elliott, 2002).

Several writers, including Mearns and McLeod (1984) and Barrineau and Bozarth (1989), have spelled out what this kind of research looks like, by applying basic person-centred principles to the conduct of therapy research:

1. The PCE therapy researcher focuses on understanding, from the inside, the client’s lived experiencing.
2. The PCE therapy researcher accepts and even prizes the client’s experiencing, and does not judge it.
3. The PCE therapy researcher tries to be an authentic and equal partner with the client, treating the client as a co-researcher and enabling client and researcher to see each other as fellow human beings.
4. The PCE therapy researcher creatively and flexibly adapts research methods to the research topic and questions at hand.

These precepts inevitably lead PCE researchers to qualitative methods, especially empirical phenomenology (the Duquesne approach; e.g., Wertz, 1983), Grounded Theory Analysis (GTA; Strauss & Corbin, 1998), along with variants such as Heuristic research (Moustakis, 1990), Consensual Qualitative Research (CQR; Hill, Thompson & Williams, 1977), and auto-ethnography/participatory inquiry (Etherington, 2004; Heron, 1996). These qualitative methods, while they differ in important ways, share many common interests with each other and with PCE therapy, including the central place accorded empathy, attention to issues of meaning, suspension of the natural attitude of having to arbitrate the nature of reality, and valuing empowerment as a goal and process in research (Mearns & McLeod, 1984). Methods such as these can be used to study just about any human experience, from being criminally victimized (Wertz, 1983) to loneliness (e.g., Moustakis, 1990). (See Box 2 for a list of common qualitative research strategies.)

[Insert Box 2 about here]

Promising possibilities for PCE therapy research

Given the considerations reviewed so far in this chapter, I think that there are many questions open for PCE Therapy research:

1. How effective are PCE therapies with specific client populations?

Both traditional group designs and RCTs continue to be very much needed, both for commonly studied populations such as depression and especially for little-studied populations such as health problems (e.g., coping with cancer) and severe problems (e.g., schizophrenia). It would also be a very good idea for researchers in our tradition to study anxiety problems, instead of leaving this topic entirely to CBT approaches.

2. How effective are PCE therapies with particular clients?

An alternative to positivist therapy research of the sort just described is the systematic case study design, in which a single client’s treatment is studied carefully and in detail in order to draw inferences about (a) whether the client changed substantially, (b)

whether therapy contributed substantially to those changes, and (c) how the changes came about (Elliott et al., 2009). Elliott and Zucconi (2006) describe a research protocol suitable for this sort of research, including a combination of qualitative and quantitative data collection formats.

3. What are the effects of the facilitative conditions on the outcome of PCE Therapies?

In a recent meta-analysis of process-outcome research on therapist empathy (Elliott, Bohart, Watson & Greenberg, 2011), we found only eight studies of PCE therapies in which this relationship had been studied! In fact, Rogers' key theoretical claim has only rarely been applied to the therapy he founded. This sort of research question is highly appropriate for naturalistic samples of PCE therapy, in which empathy is measured by client, therapist and/or observers during therapy and used to predict amount of pre-post client change. (See Elliott et al., 2011, for more suggestions for research on therapist empathy.)

4. What are the immediate in-session effects of therapist facilitative responses on depth of client processing?

The relationship between specific therapist facilitative responses (eg empathic reflections) and productive client responses within PCE therapy sessions has been studied extensively by Sachse (see Sachse & Elliott, 2002, for a summary), but most of Sachse's somewhat controversial findings, which suggest a high degree of therapist influence on client process, have not yet been replicated by others, making this a prime topic for further PCE therapy research.

5. What do clients experience as most helpful in PCE Therapy?

If the preceding research topics seem too positivistic, a purely phenomenological strategy can be used, in which clients are asked to describe in their own words what they found most helpful, either in particular sessions, using the Helpful Aspects of Therapy (HAT) Form (Llewelyn, 1988), or overall looking back over their therapy, using the Change Interview (Elliott, Slatick & Urman, 2001). These accounts can then be analyzed using Grounded Theory Analysis (GTA) or a similar qualitative method (for more information, e.g., Elliott & Timulak, 2005).

6. What are the characteristics of transformative moments in therapy?

The idea that there are special moments of insight, awareness, relief or other forms of personal healing in therapy is a key theme in the PCE therapy literature, dating back to Rogers' writings on the therapy process (e.g., Rogers 1961). Using the Helpful Aspects of Therapy Form or the more intensive Brief Structured Recall method (Elliott & Shapiro, 1988), PCE therapy researchers can identify important moments from clients' perspectives and then investigate them further in order to unpack the process of change, including the momentary qualities of the client's experience and the accompanying discourse.

7. What do PCE therapists know about how to help facilitate different kinds of productive client work in therapy?

Experienced, skilled PCE therapists have large amounts of implicit knowledge about therapeutic processes, that is, what to do when. Using tape-assisted recall methods (Elliott, 1986) and task analysis (Greenberg, 2007), the wisdom of experienced PCE therapists can be tapped by researchers. How do skilled PCE counsellors help their clients get what they want to get out of sessions? What markers do these counsellors look out for in sessions, and what do they do in response to these markers?

8. What are the effects and change processes in PCE therapy/counselling training?

Finally, we don't understand much about the outcomes of training courses in PCE therapy or counselling. In the future, such course are likely to be called upon to demonstrate their effectiveness, in terms of personal and professional functioning and ultimately quality of process and outcome with clients. We also don't understand the change processes in our training courses or which training practices are effective or ineffective. (See Elliott & Zucconi, 2006, for some suggestions.)

Other research questions and investigative strategies are possible; for example, participatory research (Whyte, 1991) and narrative research (McLeod, 2001).

[Insert Box 3 about here]

Conclusion

Clearly, many possibilities exist for Person-Centred therapists to reclaim their scientific heritage, building on recent developments and continually emerging new resources for practical, humanizing research that is completely consistent with the core values and practices of PCE therapies. Not only is research a political necessity, it is also one of the purest expressions of the actualizing tendency!

Points for Reflection

- Are researcher allegiance effect inevitable in comparative outcome studies? How might they be reduced?
- What might truly person-centred outcome research look like?
- What are the underlying philosophical assumptions of RCTs?
- What are you personally curious to learn about person-centred-experiential psychotherapy?
- What research methods would you be willing to implement in your practice with clients?

Annotated further sources

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Box 1.
Eilidh Confronts the CORE-OM.

Eilidh is a moderately depressed, 30 year old estate agent in an RCT comparing person-centred therapy to CBT. At her meeting with the researcher before her first session she is given a set of outcome questionnaires to complete, starting with a widely used measure of general psychological distress, the CORE-OM. On the CORE-OM she is asked to rate how often she has had each of a series of 34 troubling experiences over the past week, using a standard 5-point scale, ranging from 0 (“not at all”) to 4 (“most or all of the time”). When she comes to the first item, “I have felt terribly alone and isolated”, she is asked to decide if this description captures the quality of her depression, and how distressed by her feelings of loneliness and isolation she has felt over the past week. After considering briefly, she chooses 3 (‘greatly distressed’). Then she goes on to rate the other 33 items. In this studies, there are three other outcome instruments, on which Eilidh is asked to rate her interpersonal difficulties (eg, she lets people push her around more than she likes), how she feels about herself (eg, she is critical and neglectful of herself), and how much in touch with her inner experiences she is (eg, she is generally focused on trying to please others and doesn’t know what she is feeling). Finally, four months later, at the end of 16 sessions of, Person-Centred counselling, Eilidh is asked to complete these same questionnaires again. Let’s say that at this point she is feeling much better, so this second time she gives a 1 (“only occasionally”) for feeling ”terribly alone and isolated”.

Box 2.

What do Qualitative Psychotherapy Researchers Do?

The different forms of qualitative research can sound mysterious and confusing; however they typically involves a series of common concrete steps. Elliott and Timulak (2005) provide a list of common practices used by qualitative researchers:

- Negotiating with the informant-client in a transparent, collaborative manner over the nature of the participation.
- Carrying out the interview in a careful, intentional manner, helping the informant to stay focused and clarifying their meanings as they attempt to put them into words.
- Transcribing the recording of the interview at the appropriate level of detail and accuracy.
- Preparing the data record by breaking it into meaning units and dropping irrelevant material.
- Constructing categories or themes to describe each meaning unit.
- Putting meaning units into existing categories, where these apply.
- Clustering or connecting categories or themes with one another in order to develop a model or story of the phenomenon.

Box 3.
How to Get Involved in Practice-Based Research

Elliott and Zucconi (2006) have offered a set of practical suggestions for PCE therapists to get involved in research:

1. Contribute to dialogues on how to measure therapy and training outcomes within person-centred psychotherapies.
2. Join an online discussion group and contribute to discussions and collections of resource materials.
3. Begin using simple research tools with their own clients and in their own training setting, including, for example, brief quantitative measures of client problem distress and therapeutic alliance, along with systematic collection of background information about client and therapist.
4. Help with translations of key research instruments; or develop research protocols for specific client population (e.g., people living with schizophrenia).
5. Contribute to psychometric research aimed at improving existing instruments.
6. Take part in formal collaborations with similarly-inclined training centers to generate data for pooling.

Table 1
Summary of Overall Pre-post Change, Controlled and Comparative Effect Sizes (ESs)
for Person-Centered Therapy (PCT) Outcome Studies

	n	m	sd
<u>Pre-Post ES (mean d)</u>			
By Assessment Point:			
Post	58	.97	.62
Early Follow-up (1-11mos.)	22	.91	.68
Late Follow-up (12+ mos)	21	1.02	.57
Overall (mES):	65	.97	.62
<u>Controlled ES (vs. untreated clients)</u>			
Mean difference in ES	20	.69	.47
PCT mean pre-post ES	18	.79	.42
Control mean pre-post ES	18	.08	.18
<u>Comparative ES vs. nonPCE therapies</u>			
Unweighted mean difference	43	+.02	.38
PCT mean pre-post ES	43	.99	.62
Comparative treatment mean	43	.97	.61
Pre-Post ES			
Comparative ES for PCT vs. CBT			
Unweighted mean difference	22	-.09	.29

Note. Unweighted Hedge's d used. Controlled and comparative ESs use average (mean) difference in pre-post ESs for conditions compared, except where these are unavailable (in which case post-tests were compared); positive values indicate pro-PCT results.