# 21 Research on person-centred/experiential psychotherapy and counselling: summary of the main findings

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## Introduction

In this chapter, I look at the main findings from more than sixty years of research of person-centred/experiential (PCE) psychotherapies. I begin by pointing out the pioneering contributions of Carl Rogers to this literature. The body of the chapter summarizes three main areas of research: first, the highly promising evidence on the quantitative effects of PCE therapies, drawing on a large meta-analysis (Elliott et al., 2013); second, research on client in-session processes, particularly the various attempts to capture the sequence by which clients change over time in therapy and the relation of these processes to outcome; and third, the contribution of therapists and therapy methods to client change, including the sometimes controversial research on therapist process guiding (e.g. chair work). I conclude with an account of how PCE therapists can become more involved in research and describe a research pathway aimed at helping their approach find a more secure place in mental healthcare policy.

Carl Rogers was one of the pioneers of psychotherapy research, essentially founding the fields of psychotherapy process research with his innovative use of early recording technology in the 1940s, controlled outcome research in the early 1950s, and modern process-outcome research in the late 1950s (Elliott and Farber, 2010).

Rogers gave up both academia and research in the early 1960s, before the modern era of psychotherapy research, a move that Lietaer (1990) has cited as a factor in the decline of the status and vitality of the person-centred approach between 1970 and 1990. However, since 1990, not long after Rogers' death, there has been a remarkable revival in the humanistic therapy tradition including the PCE therapies. Around that time, PCE therapists woke up to the fact that they were beginning to be systematically and progressively excluded from training and healthcare 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 process guiding/experiential/emotion-focused part of the tradition (e.g. Lietaer, 1990; Greenberg et al., 1994).

Over the past twenty-five years, outcome research on person-centred and experiential therapies has proliferated, paralleled by the rapid emergence and acceptance of qualitative research. In fact, both quantitative ('positivist') outcome research and qualitative research on the experiences of clients and therapists are part of Rogers' legacy. Moreover, it has become increasingly obvious that pursuing quantitative outcome research is a political necessity to meet the demands of government and professional panels, which have pushed for restrictive forms of *evidence-based practice* (EBP; e.g. Roth and Fonagy, 2004) as part of efforts to regulate psychotherapy and counselling and to protect the public (Elliott et al., 2013). In this chapter, I summarize the fruits for this flowering of research on PCE psychotherapy and counselling, including the emergence of *practice-based evidence* (PBE; e.g. Barkham et al., 2001).

## How effective are PCE and related humanistic forms of psychotherapy and counselling?

### General effects of humanistic-experiential psychotherapies

Since the late 1940s, PCE psychotherapies specifically (and humanistic-experiential psychotherapies in general) have been the subject of more than 200 quantitative outcome studies (Elliott et al., 2013). Since 1992, my colleagues and I have used meta-analysis methods to statistically combine the results of these studies. In doing so, we used a standard measure of effect size, known as the standardized difference of the means. (That is, we found the difference between the pre-therapy mean and the post-therapy mean, and divided this by the averaged standard deviation. For controlled and comparative studies, we first calculated pre-to-post effects in each condition, then we found the difference between the amount of change in each condition.) This body of research has produced the following main findings:

1 *PCE psychotherapies are associated with large pre-post client change.* Using a 2008 sample, Elliott et al. (2013) looked at data from 191 studies, involving 14,235 clients, and reported a large pre-post effect size of 0.93. Furthermore, this was particularly true for general symptom measures (e.g. Stiles et al., 2006) involving person-centred counselling.
2 *Clients' large post-therapy gains are maintained over early and late follow-ups.* Following therapy, Elliott et al. (2013) found that clients in PCE therapies maintained and slightly improved their gains. The maintenance of gains post-therapy is consistent with Rogers' assumption of an actualizing tendency, suggesting that clients continue to develop on their own after they have left therapy.
3 *Clients in PCE therapies show large gains relative to clients who receive no therapy.* Elliott et al. (2013) analysed data from 62 controlled studies, 31 of which were randomized ($n$ = 2144 in PCE therapies vs. 1958 in wait-list or no-therapy conditions). They found a large controlled effect size (0.76; randomization made no difference). This finding provides strong support for PCE therapies, indicating that clients use them to help themselves to change.

4 *PCE therapies in general are clinically and statistically equivalent to other therapies.* In 100 studies, 91 of which were randomized ($n$ = 6097 clients), there was virtually no overall difference between PCE therapies and other therapies in amount of pre-post change (comparative effect size = 0.01).
5 *So-called non-directive-supportive therapies (NDSTs) have worse outcomes than CBT.* However, Elliott et al. (2013) found that treatments labelled by researchers as 'supportive' or 'non-directive'-have somewhat smaller amounts of pre-post change than cognitive-behavioural therapy (CBT; thirty-seven studies; effect size = –0.27). In general, these therapies turned out to be watered-down, non bona fide versions of person-centred counselling, apparently used by CBT researchers to make their treatments look better.
6 *Person-centred therapy is as effective as CBT.* In twenty-two studies, person-centred therapy was equivalent to CBT in amount of client pre-post change (effect size = –0.06).
7 *PCE therapies are most effective for interpersonal/relational problems/trauma.* For a range of interpersonal or relational problems (including couples difficulties and complex trauma or childhood abuse), Elliott et al. (2013) found very large pre-post and controlled effects, as well as significantly better comparative effects for PCE therapies, thus meeting criteria as evidence-based treatments.
8 *PCE therapies meet criteria as evidence-based treatments for depression.* For depression in general, humanistic therapies have been extensively researched with a strong evidence base pointing to large pre-post gains and equivalence to other therapies, including CBT. Emotion-focused therapies for moderate depression and person-centered counselling for perinatal depression have the most solid evidence (Elliott et al., 2013).
9 *For psychotic conditions, PCE therapies appear to meet criteria as evidence-based treatments.* Although based on a relatively small number of studies, the evidence analysed by Elliott et al. (2013) showed large pre-post effects and more change than other therapies, suggesting that person-centred and related therapies may be effective with clients experiencing psychotic processes (e.g. schizophrenia). This is at odds with the current NICE guidelines for schizophrenia, which state that 'supportive counselling' is contraindicated (National Collaborating Centre for Mental Health, 2010).
10 *PCE therapies have promise for helping people cope with chronic medical conditions and for reducing habitual self-damaging activities.* Coping with difficult medical or physical conditions (e.g. cancer) and habitual self-damaging activities (e.g. substance misuse) present challenges for all forms of therapy. However, Elliott et al. (2013) found that for both of these client populations, PCE therapies were generally associated with moderate pre-post improvement, better than no treatment controls, and equivalent to other approaches (most commonly CBT).
11 *For anxiety difficulties, the PCE therapies studied so far appear to be less effective than CBT.* In contrast to the favourable results for other client populations, PCE therapies did not fare as well as CBT when applied to anxiety (especially panic and generalized anxiety; Elliott et al., 2013; see also

Elliott, 2013a, 2013b). Although researcher bias is a factor here, Elliott et al. argued that work is required to develop more effective process-guiding approaches to anxiety, as indicated by evidence now emerging from ongoing research (e.g. Timulak and McElvaney, 2012).

### How do clients contribute to change in PCE therapies?

Researchers in the PCE tradition, going back to Rogers (e.g. Walker et al., 1960), have long had an interest in understanding the client change process and its relation to outcome.

1 *Qualitative change process research illustrates how clients use therapy to change themselves.* In a series of classic studies of the moment-by-moment experiences of clients in person-centred and Gestalt therapy sessions, Rennie (e.g. 1992, 1994) documented many interesting phenomena, showing how during therapy sessions clients are engaged in a two-fold process of pursuing personal meaning for themselves while also monitoring the therapist. Although often ambivalent about change or accessing painful experiences, clients actively evaluated therapist interventions in terms of compatibility with their agendas for the session. At the same time, clients also deferred to their therapists, preferring to tolerate therapist shortcomings rather than explicitly challenging them.

2 *Several useful measures of productive client in-session process have been developed.* In PCE theories of personality change (e.g. Rogers, 1959; Greenberg and Van Balen, 1998), depth of experiential self-exploration is described as central to client change. Experiential self-exploration has been conceptualized and measured in various ways, starting with Rogers' Process Scale (Walker et al., 1960) and the Client Experiencing Scale (Klein et al., 1986), followed by, among others, Sachse's Processing Mode Scale (1992).

   Current research is continuing to look at elements of client assimilation of difficult experiences (Stiles, 1999), narrative and autobiographical memory (Angus, 2012), emotion regulation (Watson et al., 2011), innovative moments (Mendes et al., 2010), and emotional productivity (Greenberg et al., 2007). These new variables and their associated process measures are providing more fine-grained tools for mapping how clients use therapy to change themselves. They support the following conclusions:

3 *Client emotional expression by itself is not sufficient for good outcome but instead requires the presence of other specific features.* Client emotional expression is most likely to lead to good outcome when it is grounded in specific autobiographical memories, accompanied by deeper levels of experiencing, and becomes more regulated and differentiated as it is explored (see research by Greenberg et al., 2007; Pascual-Leone and Greenberg, 2007; Angus, 2012).

4 *The most productive sequence of narrative exploration in therapy begins with description of external events, leading to initial self-reflection, leading to access to internal experiences, leading to self-reflection on broader meanings* (Angus, 2012).

5 *New narratives emerge and become established in clients' lives by a spiralling movement between action and reflection.* This process starts with attempts to change the problem, leading to reflection on the nature of the old problematic narrative, followed by active protest or working against the problem, then to emerging re-conceptualization of self and the process of change, and finally to carrying out changes in one's life (e.g. Mendes et al., 2010).

## How do therapists and therapy methods contribute to change in PCE therapies?

I now briefly review the main conclusions from quantitative research on therapist contributions to client change. These studies have generally produced somewhat weaker, less consistent results than the outcome research summarized earlier; however, some conclusions appear to be reasonable:

1 *Therapist-offered facilitative conditions consistently predict quantiative therapy outcomes but are not the whole story.* Most of the evidence for the therapist facilitative conditions described by Rogers (1957) uses in-therapy quantitative ratings by clients, therapists or observers to predict post-therapy outcome. Recent comprehensive reviews collected by Norcross (2011) provide a summary of the evidence supporting these therapist relational conditions, including Elliott et al. (2011) on empathy, Farber and Doolin (2011) on positive regard and affirmation, and Kolden et al. (2011) on congruence/genuineness.

   However, the research on therapist conditions collected and meta-analysed by Norcross (2011) comes from a broad range of therapies, most of which is not from the PCE tradition. In addition, while more larger and more consistent than differences between types of therapy or therapist technique, these conditions really only account for about 10% of the variability in client outcome, so there is a lot of room for other factors to come in, especially client differences.

2 *Process-guiding PCE therapies appear to be slightly but inconsistently more effective than non-directive ones.* The issue of process-guiding versus non-directivity has often been controversial within the person-centred approach; however, Elliott et al. (2013) reported that process-guiding therapies (especially emotion-focused therapy) did better against CBT than non-directive/supportive or person-centred therapies. However, in nine studies directly comparing more versus less process-guiding therapies, more process-guiding approaches were only trivially and inconsistently better.

3 *Research supports the use of specific therapist-offered process-guiding methods.* There is some research that points to the effectiveness of experiential techniques in more process-guiding forms of PCE therapy (e.g. emotion-focused therapy). These studies mostly involve a research method called *task analysis*, which begins with researcher-practitioners intensively analysing common issues that clients bring to sessions ('tasks'), such as internal conflicts or puzzling personal reactions to situations; they then identify therapeutic methods that clients can use to move towards resolution on these tasks.

These task models, including the essential components of resolution, are then tested in outcome studies.

For example, many humanistic-experiential psychotherapies have drawn on psychodrama and Gestalt therapy traditions to develop different forms of in-session 'enactments'. Most commonly, these methods involve the client moving between two chairs in order to carry out a conversation between an inner critic and another part of the self that is being criticized (i.e. *two-chair work for conflict splits*); alternatively, the client be asked to imagine a person important to them in an empty chair and to speak to them. The model of two-chair dialogue for conflict splits has been tested in a series of studies (e.g. Greenberg and Webster, 1982). More recently, Shahar and colleagues (2012) examined the effectiveness of the two-chair dialogue task with nine clients judged to be self-critical. The use of this task was associated with clients becoming significantly more compassionate and reassuring towards themselves, and to significant reductions in self-criticism, depression, and anxiety. Similarly, *empty chair work* has been found to be more immediately effective in resolving unfinished business compared with standard empathic responding (Greenberg and Foerster, 1996). Furthermore, clients who resolved their unfinished business reported significantly greater improvement on a wide range of measures of psychological distress and functioning (Greenberg and Malcolm, 2002). In addition, Paivio et al. (2010) found that clients required to use empty chair work to work on childhood abuse showed more pre-post change but dropped out at a higher rate than clients who instead spoke to an empathic therapist, suggesting that it may not be a good idea to require all clients to use this highly evocative therapeutic task.

4 *Regardless of their intent, therapists clearly influence client in-session process*. In an important line of research, Sachse (1992; see summary in Sachse and Elliott, 2002) found that clients only deepen their process on their own about 10% of the time. However, therapists can help clients deepen by using brief, accurate responses focusing on central client issues, delivered in the context of a strong therapeutic relationship. Most importantly, it is quite easy for therapists to interfere with client in-session working: when therapists offer superficial or externalizing reflections, clients generally follow them. Thus a key piece of advice for PCE therapists is to not get in the client's way when they are moving into deeper territory.

## Conclusion: Get involved in PCE psychotherapy research

Research on PCE psychotherapy and counselling is not just a spectator sport; it is my view that all of us involved in this approach have a role to play in advancing our approach through research that builds up bodies of practice-based evidence (PBE). This is not just a matter of political expediency but also to support our own growth tendency and that of our clients. How can you get involved? Here are some ways:

1 *If you are not already doing so, you can begin monitoring outcome with your own clients*. Simple, free measurement tools are available for tracking

your clients' progress. These include the CORE Outcome Measure (Barkham et al., 2001), a well-established measure of client psychological distress that is free to use and easy to score (if you want the test publisher to score it for you, you will have to pay for that). It exists in various incarnations, the most useful of which are the 34-item version (CORE-OM; good to give at the beginning of therapy) and a 10-item version (CORE-10; good for weekly outcome tracking). If you don't like the CORE's focus on symptom-related distress, then you might find the Strathclyde Inventory (Freire, 2007) more agreeable, since it is based on Carl Rogers' writings about congruence and incongruence. Giving a measurement instrument like one of these at the beginning of therapy will provide a useful baseline against which to track client progress (or lack thereof); after that, it's a good idea to re-administer the instrument regularly during therapy (preferably at least every other session).

2 *Adding an assessment of client-perceived change processes can provide useful feedback for improving your work with clients.* Once you have become used to monitoring client outcomes, you are likely to be curious about what is or is not working for your clients. To assess this, you might consider a qualitative data collection instrument, such as the post-session Helpful Aspects of Therapy Form (HAT; Llewelyn, 1988) or the Change Interview (Elliott et al., 2006). These instruments include open-ended questions about what clients have found most helpful or hindering in the session. (Be clear with your clients why you are collecting these data and what you will do with the information.)

3 *Building on the first two steps, it is then fairly straightforward to conduct one or more mixed-methods systematic single case studies* (McLeod, 2010). Such case studies are feasible for even a single, committed practitioner. Thanks to the increased recognition of case study research, such studies can be published in a variety of journals, including *Person-Centered and Experiential Psychotherapies*, thus providing an initial level of recognition. This will help you get your foot in the door. (Even if you are not doing this in a university or other context that requires ethical review, ensure you consider ethical issues such as client consent and confidentiality; see McLeod, 2010.)

4 *Next, you can form a practitioner research network, or join an existing one.* Practitioner research networks (PRNs; e.g. Castonguay et al., 2013) consist of groups of practitioners with shared interests, who come together to collect practice-based evidence on their work with clients using a common data collection protocol. Some of these PRNs use on-line data collection facilities (e.g. Sales et al., 2014), which facilitate the collection of substantial amounts of low-cost uncontrolled practice-based evidence. An example of PRN for PCE therapists is the one organized with the British Association for the Person-Centred Approach (BAPCA; Murphy, 2012). Studies based on pooled PRN data can provide valuable initial evidence for the effectiveness of applications of PCE psychotherapies to new client populations.

5 *Conduct a small or medium-sized randomized study.* If the previous steps have whetted your appetite for research, your next move would be to carry out a pilot study on your application of PCE therapy to a particular client

population or situation. Most often, this takes the form of a relatively small randomized study comparing the PCE therapy with a wait-list control, 'treatment as usual' or other psychological therapy. This approach requires treatment manuals (describing how the PCE therapy can be applied to the particular client population or situation) and adherence/competence measures (used to make sure that therapists are actually carrying out the therapy properly; e.g. Freire et al., 2014). As part of the design, you can collect systematic qualitative data to better understand the effects of therapy and the change processes involved. To do this, you probably need to form alliances with proponents of more established approaches and seek collaborative grants, and of course you would need to deal with complex ethical issues that such studies raise.

Further steps towards recognition might include high-profile studies, political networking, and membership of guideline development groups. From such positions, you can influence mental health treatment policy simply by being present in order to keep the process fair, and to provide alternative readings of the available research evidence.

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