Psychotherapy: Theory, Research, Practice, Training
2005, Vol. 42, No. 1, 37–51

0033-3204/05/$12.00 DOI: 10.1037/0033-3204.42.1.37

THE CURRENT STATUS OF CARL ROGERS AND THE PERSON-CENTERED APPROACH

HOWARD KIRSCHENBAUM AND APRIL JOURDAN
University of Rochester

This investigation of Carl Rogers's work explores the current status of the client-centered/person-centered approach within the United States and internationally. The status is revealed 1st by the volume of person-centered literature that has been published since Rogers's death in 1987. The prevalence of Rogers's work is also measured in the number of professional organizations, institutes, and journals dedicated to the person-centered approach. Finally, recent research on therapy outcomes, common factors, the working alliance, and therapeutic relationships has validated 2 or 3 of Rogers's core conditions—empathy, unconditional positive regard, and, possibly, congruence—as being critical components of effective psychotherapy.

The historical influence that Carl R. Rogers (1902–1987) had on the field of clinical psychology, psychotherapy, and counseling is widely known—but what prevalence does Rogers's work still have today? Have current trends in research and practice rendered Rogers's contributions to that of historic, foundational interest only, or are Rogers's contributions still valid, relevant, and alive in the 21st century? This study seeks to answer this question by examining three areas in which the status of Rogers's work may be ascertained—the number of publications on the client-centered/person-centered approach, the extent of person-centered organizations and training institutes around the world, and the role of client-centered principles in the last several decades of research on psychotherapy process and outcomes.

Howard Kirschenbaum and April Jourdan, Department of Counseling and Human Development, University of Rochester.

April Jourdan is now at Abraham Lincoln High School, San Francisco Unified School District, San Francisco, California.

Correspondence regarding this article should be addressed to Howard Kirschenbaum, EdD, Department of Counseling and Human Development, Warner Graduate School of Education, University of Rochester, Rochester, NY 14627. E-mail: howard.kirschenbaum@rochester.edu

Historical Influence

Carl Rogers and his colleagues were the first to record, transcribe, and publish complete cases of psychotherapy (C. R. Rogers, 1942). Using these recordings, Rogers conducted and sponsored more scientific research on psychotherapy than had ever been undertaken before (e.g., C. R. Rogers & Dymond, 1954; C. R. Rogers, Gendlin, Kiesler, & Truax, 1967). Rogers developed the "nondirective," "client-centered" approach to counseling and psychotherapy, which became a mainstay of therapists' repertoires (C. R. Rogers, 1942, 1951). In so doing, he popularized the term "client" as the recipient of therapy in nonmedical settings, virtually founded the professional counseling movement (Capuzzi & Gross, 2001; Gibson & Mitchell, 1999; Gladding, 2000; Nugent, 2000), and made professional counseling available to diverse helping professions. For these accomplishments, he was the first psychologist or psychotherapist ever to receive the American Psychological Association's (APA's) highest scientific *and* professional honors: its Distinguished Scientific Contribution Award (APA, 1957) and its Distinguished Professional Contribution Award (APA, 1973).

C. R. Rogers's "self-theory" (1959) became a prominent theory of personality that is still included in most personality texts today (e.g., Cloninger, 2003; Feist & Feist, 2001; Hall, Lindzey, & Campbell, 1998; Monte & Sollod, 2002; Ryckman, 2004). He served as President of the American Association of Applied Psychology, the American Association of Psychotherapists, the

APA, and the APA Division of Clinical Psychology, among other offices (Kirschenbaum, 1979). He became a leading spokesperson for the humanistic psychology movement (e.g., C. R. Rogers & Skinner, 1956) and for encounter groups (C. R. Rogers, 1970), and his many books, including *On Becoming a Person* (Rogers, 1961), helped bring the tenets of the client-centered, and later "person-centered," approach to ever wider audiences (C. R. Rogers, 1969, 1977, 1980).

Current Status

What has occurred since then? Is Rogers's presence as strong as ever, or has it faded as research on other approaches has proliferated, new knowledge about therapy has emerged, protocols for research funding have changed, and other models, trends, and pop psychology movements have developed? Without the living example of Carl Rogers—teaching, writing, and demonstrating his theories and methods around the world—have other researchers and practitioners continued to carry out and develop the client-centered/person-centered approach?

Assessing the prevalence of a therapeutic approach is no simple task. There are some objective data that help shed light on the question, but some interpretation of current trends and research findings also are required to understand the ebb and flow of a professional movement. As an initial attempt to assess the current status of Carl Rogers's and the person-centered approach, we explore three indices: the number of publications in the field, the proliferation of the person-centered approach around the world, and current research on the client-centered approach and psychotherapy outcomes.

Number of Publications

One measure of prevalence is the number of publications appearing on a particular person or approach. By one count, from January 1, 1987 to September 6, 2004, 141 books, 174 book chapters, and 462 journal articles appeared on Carl Rogers or the client-centered/person-centered approach (see Table 1).

Therefore, not counting his own writings, more books and articles were written on Carl Rogers and the client-centered/person-centered approach in the 17 years after his death than were written in the previous 40 years. If most of these publications simply made reference to Rogers's or the client-centered approaches' historical role, this might not be significant; but, in fact, our scanning of these publications indicates that the majority are describing new research, new theory, and new applications.

TABLE 1. Number of Publications on Carl Rogers and the Person-Centered Approach

Publication	1946–1986	1987–2004
Books	84	141
Book chapters	64	174
Journal articles	456	462
Total	604	777

Note. Based on bibliographies in Russell (2002) and a search of the PsycINFO database (January 25, 2002, and September 6, 2004) (not counting Rogers' own 16 books and over 200 chapters and articles). The PsycINFO database can be accessed (by subscription) from the American Psychological Association (http://online.psycinfo.com).

The numbers above reflect primarily the psychology literature. As Rogers's work has permeated many different professions—social work, education, pastoral counseling, group leadership, and others—databases for other fields would certainly reveal many more publications.

It should also be pointed out that the citations included above reflect primarily a narrow construction of the client-centered or person-centered approach. In the past 30 years, there have been at least two offshoots of the client-centered approach, often known as "focusing" (Gendlin, 1978, 1996) and "process-experiential" (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984, 1990), which remain closely aligned with the person-centered movement. For example, on the Focusing Institute's Web site, Wiltschko (1994) stated, "Focusing Therapy is a form of client-centered therapy, is part of the person-centered approach" (p. 2). Process-experiential therapy combines the person-centered and Gestalt approaches but remains essentially person centered. As Elliott (2003) wrote, "Working effectively with clients requires adapting the therapist's approach to the client's general presenting problems, the within-session task, and the client's immediate experience in the moment" (p. 2). "Davis (1995) found that more than three quarters of PE therapists' responses were either empathic understanding (57%) or empathic exploration (19%), and that process-directing responses occurred at a rate of about 8%" (Elliott & Greenberg, 2001, p. 290).

A thorough bibliography including focusing and process-experiential approaches would yield many more titles and present a more accurate reflection of the current influence of the person-centered approach. Indeed, Lietaer (2002a) included 477 books on client-centered/experiential psychotherapy from 1939–2000, many in languages other than English, about twice as many titles as shown in Table 1.

How do these numbers compare with other approaches? Using only the PsycINFO database for comparison, 777 books, chapters, and articles on Rogers and the client-centered/person-centered approach were found between 1987 and 2004. Again, this is only a portion of the actual number, but confining ourselves to a single database allows an apples-to-apples comparison among approaches. Table 2 compares the number of publications on various, major approaches to psychotherapy.

Of course, these numbers do not tell the whole story. Aside from excluding many citations not listed in the PsycINFO database, they do not indicate the content or type of publications. For example, the large number of publications on Freud and psychoanalysis appear largely in psychoanalytic journals in the United States and abroad. Very few appear in general publications, meaning that the authors are mostly speaking to themselves. They focus almost exclusively on theory and practice issues, with practically no controlled outcome studies. Publications on the person-centered approach, in contrast, appear in a wide variety of journals and publications and often include rigorous empirical research.

By this narrow measure, then, it appears that the person-centered approach, although by no means a leading topic of scholarship in psychotherapy and psychology, is alive and well. There is a steady stream of publications on theory, research, and practice in this area.

TABLE 2. Number of Publications on Various Approaches to Psychotherapy

Search descriptors	No. of publications
Sigmund Freud or *psychoanalysis*	22,436
Family systems therapy or *family therapy* (*Family systems therapy* alone = 127)	9,838
Aaron Beck or *cognitive therapy*	7,963
B. F. Skinner or *behavioral therapy*	2,788
Cognitive behavioral therapy	2,273
Carl Rogers or *client-centered therapy* or *person-centered therapy*	777
Fritz Perls or *Gestalt therapy*	620
Albert Ellis or *rational emotive therapy*	581
Multicultural counseling	448
Alfred Adler or *Adlerian therapy*	364
Psychodynamic therapy	363
William Glasser or *reality therapy*	336
Viktor Frankl or *existential therapy*	328
Eclectic approach or *integrative therapy*	223

Note. Based on a search of the PsycINFO database (September 5, 2004). Descriptors are sometimes controlled by PsycINFO. For example, when one types *behavior therapy,* PsycINFO tells the user to use the *behavioral therapy* descriptor. To derive the number for cognitive therapy, we had to ask for *cognitive therapy, not behavior and not behavioral.* We recognize that more than one person's name is associated with any particular approach, but we only used one name so as to render a fair comparison.

Professional Organizations and Journals

Another measure of status is the number of professional organizations and journals using the ideas of Carl Rogers and the client-centered/person-centered approach. Currently, there are approximately 200 organizations and training centers located around the world dedicated to researching and applying the principles developed by Rogers (see Table 3). Many of these countries have more than one client-centered/person-centered organization. This table provides only a sample of person-centered organizations around the world.

Some of these organizations are fairly small, such as the Association for the Development of the Person-Centered Approach in the United States with only a few hundred members. Others are quite large and active, such as the Gesellschaft fur Wissenschaftliche Gesprachspsychotherapie in Germany, with over 4,300 members; the British Association for the Person-Centered Approach in England, with over 1,000 members; and the Association Francophone de Psychothérapie Centrée-sur-la-Personne et Experientielle in Belgium with over 1,000 members. As these examples suggest, Europe is currently the most active center for research, training, and practice in the person-centered approach, and the person-centered approach is one of the leading therapeutic approaches on that continent.

Furthermore, there are Focusing Institutes located throughout Europe, India, Israel, Japan, Taiwan, Thailand, New Zealand, Australia, Canada, and the United States (Focusing Institute, 2003). As mentioned earlier, the experiential fo-

TABLE 3. Examples of Person-Centered Organizations Around the World

Country	Organization
Argentina	A.E.D.E.C.e.P.—Asociación para el estudio y desarrollo del Enfoque Centrado en la Persona
Austria	PCA — Person-Centered Association in Austria
Belgium	A.F.P.C. — Association Francophone de Psychothérapie Centrée-sur-la-Personne et Expérientielle VVCgP — Vlaamse Vereniging voor cliëntgerichte psychotherapie (Flemish-speaking society)
Brazil	C.E.P./RS — Centro de Estudos da Pessoa
Canada	CRAM—Centre de Relation d'Aide de Montréal
Czech Republic	PCA Institut Praha
France	PCAI-F — Person-Centered Approach Institute
Germany	GwG — Gesellschaft für wissenschaftliche Gesprächspsychotherapie
Greece	PCA—Hellenic Association of Person-Centered Approach
Hungary	HAPCCPM—Hungarian Association for Person-Centered Psychotherapy and Mental Health
Italy	IACP—Istituto dell'Approccio Centrato sulla Persona
The Netherlands	VCgP—Vereniging voor Cliëntgerichte Psychotherapie
Portugal	APPCPC—Associação Portuguesa de Psicoterapia Centrada na Pessoa e de Counselling
Scotland	PCT—Person Centred Therapy
South Africa	APCASA—Association for the Person-Centered Approach South Africa
Switzerland	SGGT–SPCP—Swiss Association for Person-centered Psychotherapy and Counseling
United Kingdom	BAPCA—British Association for the Person-Centred Approach
United States	ADPCA—Association for the Development of the Person-Centered Approach

Note. Based on authors' research and Peter Schmid's Web site (www.pfs-online.org), which has a complete listing of organizations and training institutes around the world.

cusing approach developed by Eugene T. Gendlin is closely aligned to the client-centered/person-centered tradition; therefore, these organizations also promote many of the ideas of the client-centered/person-centered approach.

In addition to the various organizations and training institutes in various countries, there are umbrella organizations that connect the individual organizations and provide a means for communicating ideas among client-centered, person-centered, and experiential theoreticians and practitioners. The World Association for Person-Centered and Experiential Psychotherapy and Counseling (WAPCEPC) was developed in 1997 during the Fourth International Conference on Client-Centered and Experiential Psychotherapy held in Portugal. Stated at the conference,

> this will be the tenth year since Carl Rogers's death and an appropriate time to take a major step to ensure the continuing vitality and influence of the distinctive approach to psychotherapy to which we are committed in our various ways. (Schmid, 2003)

Another organization to emerge from this conference was the Network of the European Associations for Person-Centered Counseling and Psychotherapy (NEAPCEPC). The purpose of the NEAPCEPC is to support client-centered/person-centered organizations throughout Europe and to ensure the presence of the approach on the European level. Both the WAPCEPC and the NEAPCEPC adhere to the following principles.

> The aim is to provide a world-wide forum for those professionals who have a commitment to the primary importance in therapy of the relationship between therapist and client, an essential trust in the experiential world of the client and its centrality for the therapeutic endeavor, a belief in the efficacy of the conditions and attitudes conducive to therapeutic movement first postulated by Carl Rogers and a commitment to their active implementation within the therapeutic relationship, a commitment to an understanding of both clients and therapists as persons who are at one and the same time individuals and in relationship with others and with their environment, an openness to the elaboration and development of person-centered and experiential theory in the light of current and future practice and research. (Schmid, 2003; see also WAPCEPC, 2004)

The influence of these organizations extends through their professional journals, which reach a wider audience than their membership and training programs. Schmid (2003) listed more than 50 person-centered or experiential periodicals and journals with primary contributions from client-centered/person-centered theorists, researchers, and practitioners. The list includes journals from Portugal, Germany, France, Great Britain, Mexico, Japan, Ireland, the Netherlands, Belgium, Canada, and the United States. There are regional journals as well, such as *Person*, published in German by the German, Austrian, and Swiss associations. On the international level, a new jour-

nal was created in 2001 by WAPCEPC. Although the journal is published in English, it includes research contributions from non-English-speaking countries.

All this activity is far more than that which occurred during Carl Rogers's lifetime. Rogers, if anything, discouraged institutes and organizations that bore his name or promulgated the client-centered approach. He was worried they would foster a personality cult or rigid orthodoxy. Rogers's death freed up a great deal of energy and initiative by person-centered theorists, researchers, and practitioners around the world, making the person-centered approach more of a broad-based, international movement than it ever was during Rogers's lifetime.

Research Findings

In 1957, "Rogers set forth a hypothesis that evoked more than 3 decades of research" (Bozarth, Zimring, & Tausch, 2001, p. 153). That hypothesis, essentially, was that when a therapist demonstrates the "core conditions" of unconditional positive regard, empathic understanding, and congruence and when the client perceives these at least to a minimal degree, then psychotherapeutic personality change and its positive correlates are inevitable. Moreover, C. R. Rogers (1957) argued that these conditions of effective therapy operated independently of the therapeutic approach being used. He wrote, "the techniques of the various therapies are relatively unimportant except to the extent that they serve as channels for fulfilling one of the conditions" (p. 102).

Among other instruments developed to assess this hypothesis, Halkides (1958) created scales with which outside judges, listening to audiotapes of therapy sessions, could rate the therapists on their demonstrated levels of the three conditions, and Barrett-Lennard (1962) created the widely used Relationship Inventory, used by clients to rate their therapists on the core conditions. Research over the next quarter century involved many studies that confirmed the efficacy of the core conditions. Truax and Mitchell (1971) reported on the results of 14 studies that involved 992 participants. Across these studies, there were 66 statistically significant correlations between positive outcome and the core conditions, versus one statistically significant negative correlation. The authors summarized,

> These studies taken together suggest that therapists or counselors who are accurately empathic, nonpossessively warm in attitude, and genuine, are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training or theoretic orientation, and with a wide variety of clients or patients, including college underachievers, juvenile delinquents, hospitalized schizophrenics, college counselees, mild to severe outpatient neurotics, and the mixed variety of hospitalized patients. Further, the evidence suggests that these findings hold in a variety of therapeutic contexts and in both individual and group psychotherapy or counseling. (p. 310)

Gurman (1977) concluded that "there exists substantial, if not overwhelming, evidence in support of the hypothesized relationship between patient-perceived therapeutic conditions and outcome in individual psychotherapy counseling" (p. 523). Orlinsky and Howard's (1986) extensive review of process–outcome studies concluded that, regarding empathic resonance, mutual affirmation, therapist role-investment (which included the patient perceiving the therapist as genuine), and the overall quality of the relationship,

> generally between 50 and 80% of the substantial number of findings in this area were significantly positive, indicating that these dimensions were very consistently related to patient outcome. This was especially true when process measures were based on patients' observations of the therapeutic relationship. (p. 365)

In contrast to the growing evidence testifying to the efficacy of the core conditions in promoting therapeutic improvement (and, conversely, low therapist conditions causing deterioration in clients), some studies showed no particular benefits resulting from one or another of the core conditions. Hence, a number of research reviews of studies in the 70s and early 80s reported equivocal findings as to the efficacy or effectiveness of the core conditions (e.g., Bergin & Suinn, 1975; Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978). Many reviewers then (Mitchell et al., 1977) and since (Bozarth et al., 2001; Elliott, 2001; Patterson, 1984) have pointed out that these studies and reviews were flawed in at least three respects.

First, the studies often used therapists who exhibited minimal levels of the core conditions. That is, many studies were comparing no facilitative conditions to minimal facilitative conditions. Patterson (1984) argued that, considering that so many studies on the core conditions found positive outcomes when therapists' levels of the conditions were minimal and when sample sizes were small only goes to demonstrate how effective the core conditions are when therapists are

trained to provide high levels of positive regard, empathy, and congruence. When researchers controlled for such bias, Stubbs and Bozarth (1994, as cited in Bozarth et al., 2001) "did not find one direct study that supported the assertion that the conditions are not sufficient" (p. 166).

Second, those who interpret studies that show no positive effect from one of the core conditions as evidence that that condition is unimportant misunderstand Rogers's hypothesis. For example, although therapist empathy in and of itself may not be a necessary condition of effective therapy (Bergin & Suinn, 1975; Lambert & Bergin, 1994), what does seem important is that clients perceive their therapist to be empathic (Barrett-Lennard, 1962; P. J. Martin & Sterne, 1976). This, in fact, was C. R. Rogers's (1957) hypothesis—the client must perceive the therapists' empathy, unconditional positive regard, and congruence. Studies that use only outside observer or therapist ratings to measure the core conditions fall short of testing Rogers's hypothesis, even though a large number have produced positive findings. The truer test of Rogers's hypothesis is achieved when the core conditions are rated by the client, and such studies have produced the most consistently positive findings.

Finally, the fact that some studies, albeit a minority, show that empathy by itself does not produce positive change does not mean that empathy is not effective; this just means that, by itself, empathy is not sufficient. The same is true for unconditional positive regard and congruence. Rogers did not suggest that *each* condition was sufficient but that *all* were sufficient. When all three conditions are present and the client perceives them, Rogers said that positive change will occur.

Later Studies and Reviews

In any case, in spite of some equivocal reviews in the 70s, most research in the 1980s and 90s continued to support the importance of the core conditions. Reviewing 12 studies, Sexton and Whiston (1994) wrote, "This research seems to support previous findings regarding the importance of empathy in the counseling relationship" (p. 15). Orlinsky, Grawe, and Parks (1994) reported similar positive results in 10 studies from this period (only one overlapping with Sexton and Whiston's sample). Bohart, Elliott, Greenberg, and Watson (2002) conducted possibly the largest meta-analysis of research on empathy, including 47 studies from 1961–2000, involving 3,026 clients, with 190 separate empathy–outcome associations studied. They found a weighted, unbiased effect size of .32, which is considered a medium effect size. In the context of psychotherapy outcome research, this would be considered a meaningful correlation between empathy and positive therapeutic outcomes. Although recognizing the importance of empathy, many researchers (e.g., Bohart et al., 2002; Duan & Hill, 1996; Gladstein, 1987; Sexton & Whiston, 1994) have suggested that empathy is a more complex concept than Rogers and others have recognized. They have argued that more research is needed to understand therapeutic empathy—its different forms and its most effective applications with different clients, in different therapeutic contexts, and at different stages of the therapy relationship.

As with empathy, of 24 relatively recent studies addressing therapists' "affirmation" of clients (a concept that includes acceptance, nonpossessive warmth, and positive regard), a large majority of the studies showed a positive correlation between affirmation and outcomes, compared with some neutral and only one negative finding (Orlinsky, Grawe, & Parks, 1994). When combined with studies from Orlinsky and Howard's (1986) review, Orlinsky, Grawe and Parks

> summarized the results of 154 findings . . . drawn from a total of 76 studies. They found that 56% of the findings were positive, and that, again, the findings based on the patients' . . . sense of the therapist's positive regard yielded even a higher rate of positive therapeutic outcomes, 65%. (Farber & Lane, 2002, p. 184)

Stated differently, there were 87 findings with a statistically significant positive relationship between therapist affirmation and positive outcomes, 63 findings that showed no relationship, and only 4 that showed a negative relationship.

Furthermore, most recent studies done following the "working alliance" model (discussed below), rather than the client-centered model, found similar findings. In 16 studies, about half of the associations between therapists' warmth/positive regard and outcomes are positive, about half show no difference, and none are negative. However, again, "as noted by previous reviewers, when the patient rates both the therapist's positive regard and treatment outcome, a positive association between these and other variables is

especially likely" (Farber & Lane, 2002, p. 185). Farber and Lane (2002) concluded,

> The therapist's ability to provide positive regard seems to be significantly associated with therapeutic success—at least when we take the patient's perspective on therapeutic outcome. However, virtually all the significant findings bear relatively modest effect sizes, suggestive of the fact that, like the therapeutic alliance, it is a significant but not exhaustive part of the process–outcome equation. Extrapolating somewhat from the data, we conclude that therapists' provision of positive regard is strongly indicated in clinical practice. (p. 191)

Research on congruence has been more ambiguous, with many studies showing a positive correlation with positive outcomes, many showing no correlation, and some showing a negative correlation (Klein, Kolden, Michels, & Chisholm-Stockard, 2002; Sachse & Elliott, 2001). Kirschenbaum (1979) wrote that congruence was the least clearly explained of Rogers's core conditions; hence, it may be the most difficult of the core conditions for therapists to get right. The research indicates, for example, that although certain amounts and types of self-disclosure by the therapist may be helpful, too much or inappropriate self-disclosure can be harmful (Orlinsky et al., 1994). Sachse and Elliott (2001) suggested that more research is needed to learn about how congruence can be used most helpfully in counseling and psychotherapy.

Research in Europe

As research on client-centered therapy in the United States diminished in Rogers's later years (Lietaer, 1990), when his professional attention turned elsewhere, research on person-centered and experiential psychotherapies increased significantly in Europe. Reinhold Tausch and his students and colleagues in Germany engaged in a major program of psychotherapy research (see Bozarth et al., 2001, for a summary of this research program). For example, in one study involving 80 client-centered therapists and 149 clients and their wait-list control clients, it was found that significant improvement in clients took place when therapists demonstrated two of the three core conditions (Rudolph, Langer, & Tausch, 1980). (Again, this recalls C. R. Rogers's, 1957, hypothesis that single conditions are not sufficient, but that all—or as this study demonstrated, at least two—of the core conditions are necessary for change.)

Studies in Belgium and the Netherlands by Lietaer and his colleagues produced similar findings (e.g., Lietaer, Rombauts, & VanBalen, 1990; Lietaer, van Praag, & Swildens, 1984; VanBalen, Leijssen, & Lietaer, 1986). Summarizing this period of research, Bozarth et al. (2001) wrote,

> The studies by Tausch and his colleagues as well as others in Europe are quite positive. Positive findings are consistent in the areas of individual psychotherapy . . .; group psychotherapy; and groups with cancer patients, prisoners, judges, teachers, and geriatric individuals. The findings extend to encounter groups, education, and daily life activities (p. 162).

Speaking more broadly, Stubbs and Bozarth (1994) wrote, "Over four decades, the major thread in psychotherapy efficacy research is the presence of the therapist attitudes hypothesized by Rogers" (p. 109).

A New Generation of Research

In spite of all the research support for empathy, positive regard, and congruence, even strong advocates of client-centered/experiential therapy have conceded or concluded that the core conditions may be neither necessary nor sufficient (Tausch, 1990). Lietaer (2002b) has pointed out that certainly there has been at least one case in which a client perceived the therapist as empathic, accepting, and real yet did not improve. This shows that the conditions are not *sufficient* for all clients. Similarly, there have been individual patients who improved even though the therapist lacked one or more of the core conditions. Hence, one cannot maintain that all the core conditions are *necessary*. As Gelso and Carter (1985) stated, "the conditions originally specified by Rogers are neither necessary nor sufficient, although it seems clear that such conditions are facilitative" (p. 220) or, as Lietaer (2002b) said, "crucial." As we would put it, although neither necessary nor sufficient for all clients, the core conditions are *helpful* to *extremely helpful* with virtually all clients.

Indeed, the direction of much of the latest research on psychotherapy outcomes is consistent with this view. This newer research has gradually come to recognize or acknowledge, first, that the success of psychotherapy is only partly determined by the psychotherapy itself, that is, by the therapist's approach, skill, attitudes, and relationship with the client. For example, on the basis of Lambert, Shapiro, and Bergin's (1986) review of the voluminous research on psychotherapy outcomes, Lambert (1992) concluded that whatever

positive change occurs during psychotherapy can be attributed approximately 45% to the psychotherapy (a combination of the therapy relationship and the therapist's techniques), 15% to the placebo effect (the client's expectation that this process will be good for him or her), and 40% to extratherapeutic variables like the social and family support systems in the client's life, the client's ego strength, and fortuitous events (see also Hubble, Duncan, & Miller, 1999; Wampold, 2001).

Another recognition of the newest generation of psychotherapy research, albeit a controversial one, is that the success of psychotherapy is not due primarily to the particular therapeutic approach—whether it be cognitive–behavioral, client-centered, psychoanalytic, or any other. Rather, these approaches are roughly equivalent in their effectiveness (Elliott, 1996; Luborsky, Singer, & Luborsky, 1975; M. L. Smith & Glass, 1977; M. L. Smith, Glass, & Miller, 1980; Wampold et al., 1997). Some research has supported the superiority of certain approaches for certain client problems, such as cognitive–behavior therapy for the treatment of depression; however, many researchers (e.g., Elliott, 2001; Luborsky et al., 1999; Robinson, Berman, & Neimeyer, 1990; Wampold, 2001) have argued persuasively that, in addition to other limitations, these studies do not take therapist "allegiance" into account. They suggest, for example, that the cognitive–behavioral therapists in these studies (and the researchers) had a level of training and commitment to cognitive–behavioral therapy that was greater than the training and commitment of the therapists in the comparison groups and that when these differences in therapist allegiance are controlled statistically, the differences in treatment approaches all but disappear.

Common Factors and Core Conditions

Hence, much of the latest research on psychotherapy outcomes has demonstrated that, rather than particular approaches, it is certain "common factors" in the therapy relationship that account for therapeutic change (Goldfried, 1980; Frank, 1982; Grencavage & Norcross, 1990; Lambert, 1992). "Our major theoretical schools, although effective, seem no better than one another. Instead, it seems that there is some set of common elements and process underlying successful therapy" (Sexton, Whiston, Bleuer, & Walz, 1997, p. 56). Although Rogers was not the first person to suggest that common factors in the therapy relationship account for its benefits (Rosenzweig, 1936, first introduced the idea), he was the first to spell out this relationship in detail and conduct extensive scientific research on it. Years later, citing Hubble et al.'s (1999) book on common factors research, *The Heart and Soul of Change*, Bozarth et al. (2001) would write that "the pervasive conclusion of decades of therapy research [is] that outcome is related to common factors rather than particular therapies" (p. 150).

The common factors in effective psychotherapy have been characterized many different ways. Lambert and Bergin (1994) cataloged *support factors*, *learning factors*, and *action factors*. Among the support factors are therapist warmth, respect, empathy, acceptance and genuineness, positive relationship, and trust. New studies conducted by non-client-centered therapists continue to support the importance of these support factors.

For example, one of the largest and best experimental studies conducted in the United States, funded by the National Institute of Mental Health (Blatt, Zuroff, Quinlan, & Pilkonis, 1996), compared three treatment approaches for depression—administration of the drug imipramine, cognitive–behavioral therapy, interpersonal therapy, and "ward management," which was meant to serve as a placebo treatment. What distinguished this study was that it involved many therapists and many patients who were randomly assigned to the various treatment groups.

> The patients were selected in terms of specifically defined criteria; three large medical centers were used in order to provide adequate samples of patients; manuals were available for each of the forms of psychotherapy being evaluated; the therapists were experienced clinical psychologists and psychiatrists who received specialized training in one of the psychotherapies being evaluated; a variety of well-known standardized evaluative procedures were used; and competent statistical consultants participated in the project. (Lambert & Bergin, 1994, p. 220)

As it turned out, there were no significant differences among the three therapeutic treatments on patient outcomes. *However*, across all groups, the therapist's empathy, positive regard, and congruence at the end of the second session were significantly correlated with outcomes. As Blatt et al. (1996) wrote, "Higher levels of an experienced therapeutic relationship [that is, as experienced by the patient] were significantly related to

better outcome, especially with the measures of change in general clinical and social functioning" (p. 166). Bozarth et al. (2001) wrote that the single best predictor of success at the end of therapy was the patients' perception of the therapist's empathy at the end of the second session.

Therapeutic Alliance and Core Conditions

In spite of the significant empirical support for Rogers's core conditions, other researchers have proposed other models as providing a more satisfactory explanation of the common factors that account for therapeutic progress. One of these is the therapeutic alliance or working alliance model, which originated in the psychoanalytic literature (Bordin, 1979; Menninger, 1958). As Sexton et al. (1997) wrote, "The working alliance, social influence and interactional models of the counseling relationship have received considerable research attention and garnered strong empirical support. The strength of the evidence for these models far exceeds that demonstrated by the prevalent Rogerian model" (p. 78). Although they present little evidence to support this claim with respect to the latter two models, research reviews and meta-analyses on the therapeutic alliance (e.g., Gaston, 1990; Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; D. J. Martin, Garske, & Davis, 2000; Orlinsky et al., 1994) have helped establish this model as a popular new explanation for effective therapeutic relationships. Orlinsky et al. (1994) wrote, "The strongest evidence linking process to outcome concerns the *therapeutic bond* or *alliance*, reflecting more than 1,000 process–outcome findings" (p. 360).

Whether it *far* exceeds the core conditions model is debatable. Lambert (1992) wrote, "Research on the therapeutic alliance has, as yet, far less research than that generated by client-centered theory" (p. 108), although subsequent research on the alliance has been profuse. "The results of the meta-analysis indicate that the overall relation of therapeutic alliance with outcome is moderate" (D. J. Martin, Garske, & Davis, 2000.) "Moderate" in this sense refers to effect size or just how large the relationship is between the alliance and the outcome. Statistically speaking, the same could be said of empathy (see Farber & Lane, 2002, above). Bohart et al. (2002) stated, "The effect size [for empathy] is on the same order of magnitude as (or slightly larger than) previous analyses of the relationship between therapeutic alliance and outcome" (p. 96). Although there is still some debate over the relative strength of the necessary and sufficient conditions and the therapeutic alliance models, nevertheless, there is little debate that recent, process–outcome research in psychotherapy has focused primarily on the common factors in the therapeutic or working alliance.

Ironically, Lambert and Bergin (1994) wrote, "There is more disagreement about the therapeutic alliance construct than there was with the client-centered conditions" (p. 165). Descriptions of the therapeutic alliance include the therapist's *engagement* (efforts to promote the process, active interventions, and showing interest) and the therapist's *collaboration* (taking a mutual, invitational, negotiating stance; Sachse & Elliott, 2001). Another description of the working alliance includes "client–counselor agreement on goals, agreement on therapeutic tasks, and the emotional bond between client and counselor" (Sexton et al., 1997, p. 78). The therapeutic alliance is influenced by other common factors (Grencavage & Norcross, 1990; Wampold, 2001, p. 150). These include the *client's belief* about the effectiveness of therapy and his or her *hope and expectation* about getting better (Frank, 1961); whether the therapist's behavior fits the client's expectations; whether the client and therapist can establish *a contract*—a mutual understanding of how they will work together, how long it will take, how much it will cost, what kind of material will be explored, and how they will do this. All these common factors affect the therapeutic outcome. Summarizing many different conceptions of the alliance concept, Gaston (1990) identified four broad dimensions:

> the therapeutic alliance, or patient's affective relationship to the therapist . . . [b] the working alliance, or patient's capacity to purposefully work in therapy . . . [c] the therapist's empathic understanding and involvement . . . [and; d] the patient–therapist agreement on the goals and tasks of treatment. (p. 145)

As Gaston's description makes explicit, and as many scholars have pointed out (Feller & Cattone, 2003), the Rogerian and therapeutic alliance explanations are not mutually exclusive. Orlinsky et al. (1994) wrote, "Theoretical interest in the therapeutic alliance . . . has continued the movement launched by C. R. Rogers's (1957) conception of the therapeutic relationship" (p. 308). Wampold (2001) wrote, "Empathy and the for-

mation of the working alliance, for example, are intricately and inextricably connected" (p. 211). Burns and Nolen-Hoeksema (1992) studied the role of empathy as one component of the therapeutic alliance when using cognitive–behavioral therapy for the treatment of depression. They reported

> The patients of therapists who were the warmest and most empathic improved significantly more than the patients of therapists with the lowest empathy ratings, when controlling for initial depression severity, homework compliance, and other factors. This indicates that even in a highly technical form of therapy such as CBT [cognitive–behavioral therapy], the quality of the therapeutic relationship has a substantial impact on the degree of clinical recovery. This is the first report we are aware of that has documented the causal effect of therapeutic empathy on recovery when controlling for the simultaneous causal effect of depression on therapeutic empathy. (p. 447)

The results were so robust that, thereafter, all patients at the medical center where the research was conducted were required to complete a "therapeutic empathy form" after each interview, so that therapists would get timely feedback if their patients perceived a lack of empathy on their part. "Thus, difficulties in the therapeutic alliance can be more rapidly identified and addressed" (p. 445).

Indeed, it is the therapist's empathy, acceptance, and genuineness that allow many clients to feel safe enough to enter into a real relationship with the therapist and be willing to develop an implicit or explicit agreement, understanding, or "contract" to engage in therapy. One client-centered therapist (McCulloch, 2000, 2003) explained how she was able to establish meaningful counseling relationships with male prisoners with diagnoses of antisocial personality disorder. Prison psychologists had given up on them; they were reluctant or refused to accompany McCulloch on her clinical rounds through the cell block. On her first visit to the cells, prisoners exposed themselves, urinated, spat toward her, and voiced obscenities. On subsequent visits, many inmates stopped these behaviors, began speaking with her, and agreed to participate in counseling sessions. Her fellow psychologists could not understand how she accomplished this, but her explanation was simple:

> I treated them like human beings. I showed concern and interest while accepting their anger without judging it. I expressed my own limits by telling them that I was distracted by their behavior, that I wanted to give them my full attention, and that I found it difficult to do so when I was distracted. I told them that I valued speaking with them and hoped we would talk when they were not doing these other things. (McCulloch, 2003)

In this case, the therapist's empathy, unconditional positive regard, and congruence made a therapeutic alliance possible. The process is similar in less dramatic cases. The core conditions both facilitate the therapeutic alliance and play an integral part in the therapeutic process. Rogers's core conditions may or may not be necessary or sufficient for effective psychotherapy (the debate is ongoing), but whether considered among the common factors of effective therapy or a means to achieve a therapeutic alliance, the value of empathy, unconditional positive regard, and congruence is supported by the latest generation of psychotherapy process–outcome research. As Lambert (1992) concluded

> Among the common factors most frequently studied have been those identified by the client-centered school as 'necessary and sufficient conditions' for patient personal change: accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness. Virtually all schools of therapy accept the notion that these or related therapist relationship variables are important for significant progress in psychotherapy and, in fact, fundamental in the formation of a working alliance (p. 104).

The Therapeutic Relationship and Empirically Supported Treatments

This is not just the conclusion of a few individual scholars or of researchers with a client-centered leaning. At the end of the 20th century, the APA Division of Psychotherapy (Division 29) created a distinguished panel to summarize the research on effective therapy relationships (Norcross, 2001). This task force, of whose 10 steering committee members none particularly identified with the client-centered approach, was in part a response to the growing movement, particularly in the United States, toward "empirically supported treatments." Federal funding of research on psychotherapy was moving strongly toward identifying those treatment approaches that were shown empirically to be effective, particularly with patients with specific diagnoses—anxiety, depression, drug abuse, and the like. Concerned that this movement essentially ignored 30 or more years of research that demonstrated that treatment approaches made relatively little difference compared with the therapeutic relationship itself, the task force was charged with summarizing the scientific research on the therapy relationship.

Published in a massive volume called *Psychotherapy Relationships That Work* (Norcross, 2002) and summarized in its professional journal (Norcross, 2001), the task force's six main conclusions were as follows.

1. The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment.
2. Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.
3. Efforts to promulgate practice guidelines or evidence-based lists of effective psychotherapy without including the therapy relationship are seriously incomplete and potentially misleading on both clinical and empirical grounds.
4. The therapy relationship acts in concert with discrete interventions, patient characteristics, and clinical qualities in determining treatment effectiveness. A comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations.
5. Adapting or tailoring the therapy relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment.
6. The following list embodies the Task Force conclusions regarding the empirical evidence on *General Elements of the Therapy Relationship* primarily provided by the psychotherapist. (Task Force on Empirically Supported Therapy Relationships, n.d., p. 2)

Evaluating the strength of the various correlations, the task force grouped qualities and aspects of the therapy relationship according to whether they were *demonstrably effective* across therapies; *promising and probably effective* across therapies; demonstrably or probably effective with particular types of clients, or not yet shown by research to be effective. The three aspects of the individual therapy relationship shown to be clearly demonstrated by the research were (not in order of importance) the therapeutic alliance, empathy, and goal consensus and collaboration. Aspects of the therapy relationship judged to be promising and probably effective were positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretations. The task force leader, referring to the Bill Clinton presidential campaign slogan, "It is the economy stupid," quipped that their findings could be summarized by the slogan, "It is the relationship, stupid!" (Norcross, 2001, p. 347).

The Move Toward Eclecticism and Integration

Consistent with this large body of research, most therapists have been moving away from a strict allegiance to specific therapeutic approaches or schools of thought (Lambert & Bergin, 1994; Norcross & Goldfried, 1992). Surveys of therapists over the past 30 years have demonstrated a growing proportion of practitioners who identify themselves as "eclectic" or "integrative" (Garfield & Kurtz, 1977; Jensen, Bergin, & Greaves, 1990; D. Smith, 1982; Norcross & Newman, 1992; Norcross & Prochaska, 1988), to the point where "the vast majority of therapists have become eclectic in orientation" (Lambert & Bergin, 1994, p. 181). In many of these surveys, although a very small percentage of practitioners identify themselves as being primarily person centered, a significant proportion of counselors, psychotherapists, and social workers (typically 25–50%) identify "Rogerian," person-centered, experiential, and humanistic methods as being a significant part of their integrative approach. One can only speculate that many more therapists, although not identifying themselves as primarily or partially person centered, nevertheless incorporate Rogers's core conditions as important ingredients in their own therapeutic approach. In this sense, Rogers's influence lives on in the practice of many, if not most, eclectic and integrative counselors and psychotherapists.

Conclusion

We have attempted to assess the current status of Carl Rogers's contributions to psychotherapy by examining three indicators of prevalence. The number of publications on Rogers and the client-centered/person-centered approach has increased substantially since Rogers's death. Person-centered associations, organizations, and training

institutes have proliferated around the world. Research on psychotherapy process and outcomes has validated the importance of empathy, unconditional positive regard, and probably congruence—Rogers's core conditions for an effective therapeutic relationship.

By all these indicators, the person-centered approach, which holds the therapeutic relationship as central and essential to effective counseling and psychotherapy, is alive and well. Although relatively few therapists describe themselves as primarily client-centered in their orientation, client-centered principles permeate the practice of many, if not most, therapists. Various schools of psychotherapy increasingly are recognizing the importance of the therapeutic relationship as a means to, if not a core aspect of, therapeutic change.

Of course, these three indicators do not tell the whole story. A thorough examination of Rogers's and the person-centered approach's current status would look more deeply at the "person-centered-experiential" movement, teasing out the distinctions between and synthesis of person-centered, focusing, and process-experiential approaches and charting their collective prevalence and vitality. One might also review the extent to which the person-centered approach may be found in current textbooks in clinical psychology, psychotherapy, and counseling; the extent to which funded research projects reflect or study person-centered principles or methods; and the extent to which person-centered approaches are reimbursed by insurance carriers in different states and countries. Another useful measure is the extent to which current practitioners identify themselves with the client-centered approach and/or Rogers's core conditions. This subject was briefly touched on above but deserves a more thorough exploration. Finally, a very important measure of status, current and future, is the extent of university training and research programs that are promulgating and studying the person-centered approach. Although there may be an impressive level of such activity today, unless a new generation of researchers and practitioners are being prepared to assume leadership in the future, any movement is bound to decline.

In any case, for now, the client-centered/person-centered approach appears to be experiencing something of a revival, both in professional activity and academic respectability. The latest generation of research on psychotherapy process and outcomes—whether couched in terms of the core conditions, common factors, or the therapeutic/working alliance—has validated many of Carl Rogers's original insights about the importance and nature of the effective therapeutic relationship. This should be acknowledged more widely in university classrooms, publications, research-funding protocols, and professional training programs. In the last area, there are many new resources available (e.g., Kirschenbaum, 2003; PCCS Books, 2004; N. Rogers, 2002; WAPCEPC, 2004) to assist university training programs and independent institutes in preparing psychotherapists, counselors, and other clinical workers.

Looking ahead, it is unclear whether the *client-centered/person-centered* approach will remain a separate and distinct orientation in psychotherapy; whether its expansion to the *person-centered-experiential* approach, as advocated by many leading person-centered scholars and researchers today, will become the accepted, wider orientation; or whether the person-centered-experiential movement will be subsumed under the more general heading of *humanistic psychotherapies* as some advocate (Lietaer, 2002c; see also Cain & Seeman, 2001). Whichever evolves, it seems likely that Carl Rogers's legacy will endure, not just as an area of study of historical importance, but as a body of research and practice that will influence the work of future researchers and practitioners for generations to come.

References

American Psychological Association. (1957, March). Distinguished scientific contribution awards for 1956—Carl R. Rogers. *American Psychologist, 12,* 125–133.

American Psychological Association. (1973). Distinguished professional contribution award for 1972. *American Psychologist, 28,* 1, 71–74.

Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs, 76*(43, Whole No. 562), 1–33.

Bergin, A. E., & Suinn, R. M. (1975). Individual psychotherapy and behavior therapy. In M. R. Rosenzweig & L. W. Porter (Eds.), *Annual review of psychology* (pp. 509–556). Palo Alto, CA: Annual Reviews.

Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64,* 162–171.

BOHART, A. C., ELLIOTT, R. GREENBERG, L. S., & WATSON, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89–108). New York: Oxford University Press.

BORDIN, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Research and Practice, 16,* 252–260.

BOZARTH, J. D., ZIMRING, F. M., & TAUSCH, R. (2001). Client-centered therapy: The evolution of a revolution. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 147–188). Washington, DC: American Psychological Association.

BURNS, D. D., & NOLEN-HOEKSEMA, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology, 60,* 441–449.

CAIN, D. J., & SEEMAN, J. (Eds.). (2001). *Humanistic psychotherapies: Handbook of research and practice.* Washington, DC: American Psychological Association.

CAPUZZI, D., & GROSS, D. R. (2001). *Introduction to the counseling profession* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

CLONINGER, S. C. (2003). *Theories of personality: Understanding persons.* Upper Saddle River, NJ: Pearson/Prentice Hall.

DUAN, C., & HILL, C. E. (1996). The current state of empathy research. *Journal of Counseling Psychology, 43,* 261–274.

ELLIOTT, R. (1996). Are client-centered/experiential therapies effective? A meta-analysis of outcome research. In U. Esser, H. Pabst, & G. W. Speierer (Eds.), *The power of the person-centered approach* (pp. 125–138). Koln, Germany: GwG Verlag.

ELLIOTT, R. (2001). The effectiveness of humanistic psychotherapies: A meta-analysis. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 57–81). Washington, DC: American Psychological Association.

ELLIOTT, R. (2003, November). *Learning emotion-focused therapy: The process-experiential approach to change* [Book description]. Washington, DC: American Psychological Association. Retrieved September 8, 2004, from The Process-Experiential Therapy Web site, http://www.process-experiential.org/learning

ELLIOTT, R., & GREENBERG, L. (2001). Process-experiential psychotherapy. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 279–306). Washington, DC: American Psychological Association.

FARBER, B. A., & LANE, J. S. (2002). Positive regard. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 175–194). New York: Oxford University Press.

FEIST, J., & FEIST, G. J. (2001). *Theories of personality* (5th ed.). Boston: McGraw-Hill.

FELLER, C., & CATTONE, R. R. (2003). The importance of empathy in the therapeutic alliance. *Journal of Humanistic Counseling, Education and Development, 42*(1), 53–61.

FOCUSING INSTITUTE. (2003). *HOME PAGE.* Retrieved November 22, 2003, from http://www.focusing.org

FRANK, J. D. (1961). *Persuasion and healing.* Baltimore: Johns Hopkins Press.

FRANK, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey and M. M. Parks (Eds.), *The master lecture series: Vol. 1. Psychotherapy research and behavior change* (pp. 73–122). Washington, DC: American Psychological Association.

GARFIELD, S. L., & KURTZ, R. (1977). A study of eclectic views. *Journal of Consulting and Clinical Psychology, 45,* 78–83.

GASTON, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*(2), 143–153.

GELSO, C. J., & CARTER, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13*(2), 155–243.

GENDLIN, E. T. (1978). *Focusing.* New York: Everest House.

GENDLIN, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method.* New York: Guilford Press.

GIBSON, R. L., & MITCHELL, M. H. (1999). *Introduction to counseling and guidance* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

GLADDING, S. T. (2000). *Counseling: A comprehensive profession.* Upper Saddle River, NJ: Merrill/Prentice Hall.

GLADSTEIN, G. A. (1987). Counselor empathy and client outcome. In G. A. Gladstein & Associates (Eds.), *Empathy and counseling: Explorations in theory and practice*. New York: Springer Verlag.

GOLDFRIED, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35,* 991–999.

GREENBERG, L., RICE, L. N., & ELLIOTT, R. (1993). *Facilitating emotional change: The moment-by-moment process.* New York: Guilford Press.

GRENCAVAGE, L. M., & NORCROSS, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21,* 372–378.

GURMAN, A. S. (1977). The patient's perception of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 503–543). New York: Pergamon Press.

HALKIDES, G. (1958). *An experimental study of four conditions necessary for therapeutic change.* Unpublished doctoral dissertation, University of Chicago.

HALL, C., LINDZEY, G., & CAMPBELL, J. (1998). *Theories of personality* (4th ed.). New York: Wiley.

HORVATH, A. O., & SYMONDS, D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139–149.

HUBBLE, M. A., DUNCAN, B. L., & MILLER, S. D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

JENSEN, J. P., BERGIN, A. E., & GREAVES, D. W. (1990). The meaning of eclecticism: New survey and analysis of components. *Professional Psychology: Research and Practice, 21,* 124–130.

KIRSCHENBAUM, H. (1979). *On becoming Carl Rogers.* New York: Delacorte Press.

KIRSCHENBAUM, H. (2003). *Carl Rogers and the person-centered approach* [Videotape]. Webster, NY: Values Associates. (Available from www.HowardKirschenbaum .com)

KLEIN, M. H., KOLDEN, G. G., MICHELS, J. L., & CHISHOLM-STOCKARD, S. (2002). Congruence. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 195–215). New York: Oxford University Press.

LAMBERT, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

LAMBERT, M. J., & BERGIN, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.

LAMBERT, M. J., SHAPIRO, D. A., & BERGIN, A. E. (1986). The effectiveness of psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 157–212). New York: Wiley.

LIETAER, G. (1990). The client-centered approach after the Wisconsin Project: A personal view on its evolution. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp. 19–45). Leuven, Belgium: Leuven University Press.

LIETAER, G. (2002a, July). *Client-centered/experiential psychotherapy and counseling bibliographical survey 1997–1999: With a special section on books 1939–2000* [Booklet distributed at the Fifth International Conference on Client-Centered and Experiential Psychotherapy]. Retrieved January 17, 2005 from http://www.pce-world.org

LIETAER, G. (2002b, July). *Remarks at Carl Rogers Symposium*. Third World Congress on Psychotherapy, Vienna, Austria.

LIETAER, G. (2002c). The united colors of person-centered and experiential therapies. *Person-Centered and Experiential Psychotherapies, 1*(1 & 2), 4–13.

LIETAER, G., ROMBAUTS, J., & VAN BALEN, R. (Eds.). (1990). *Client-centered and experiential psychotherapy in the nineties.* Leuven, Belgium: Leuven University Press.

LIETAER, G., VAN PRAAG, P. P., & SWILDENS, J. (1984). *Client-centered psychotherapie in beweging* [Client-centered psychotherapy in action]. Leuven, Belgium: Acco.

LUBORSKY, L., CRITS-CHRISTOPH, P., MINTZ, J., & AUERBACH, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes.* New York: Basic Books.

LUBORSKY, L., DIGUER, L., SELIGMAN, D. A., ROSENTHAL, R., KRAUSE, E. D., JOHNSON, S., ET AL. (1999). The researcher's own therapy allegiances: A "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice, 6*(1), 95–106.

LUBORSKY, L., SINGER, B., & LUBORSKY, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes?" *Archives of General Psychiatry, 32,* 995–1008.

MARTIN, D. J., GARSKE, J. P., & DAVIS, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438–450.

MARTIN, P. J., & STERNE, A. L. (1976). Post-hospital adjustment as related to therapists' in-therapy behavior. *Psychotherapy Theory, Research and Practice, 13,* 267–273.

MCCULLOCH, L. (2000). A person-centered approach to anti-social personality disorder (Doctoral dissertation, University of Rochester, 2000). *Dissertation Abstracts International, 61* (09A), 3475.

MCCULLOCH, L. (2003, January). *The person-centered approach in crisis and calm*. Panel presentation at the 13th Annual Counselor's Renewal Conference, University of Rochester, Rochester, NY.

MENNINGER, K. (1958). *Theory of psychoanalytic technique.* New York: Basic Books.

MITCHELL, K. M., BOZARTH, J. D., & KRAUFT, C. C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, nonpossessive warmth, and genuineness. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 482–502). New York: Pergamon Press.

MONTE, C., & SOLLOD, R. (2002). *Beneath the mask: An introduction to theories of personality* (7th ed.). Hoboken, NJ: Wiley.

NORCROSS, J. C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy, 38,* 345–356.

NORCROSS, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* New York: Oxford University Press.

NORCROSS, J. C., & GOLDFRIED, M. R. (Eds.). (1992). *Handbook of psychotherapy integration.* New York: Basic Books.

NORCROSS, J. C., & NEWMAN, C. F. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3–45). New York: Basic Books.

NORCROSS, J. C., & PROCHASKA, J. O. (1988). A study of eclectic (and integrative) views revisited. *Professional Psychology: Research and Practice, 19,* 170–174.

NUGENT, F. A. (2000). *Introduction to the profession of counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.

ORLINSKY, D. E., GRAWE, K., & PARKS, B. K. (1994). Process and outcome in psychotherapy: *Noch einmal.* In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–376). New York: Wiley.

ORLINSKY, D. E., & HOWARD, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311–381). New York: Wiley.

PARLOFF, M. B., WASKOW, I. E., & WOLFE, B. E. (1978). Research on therapist variables in relation to process and outcomes. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 233–282). New York: Wiley.

PATTERSON, C. H. (1984). Empathy, warmth, and genuineness in psychotherapy: A review of reviews. *Psychotherapy, 21,* 431–438.

PCCS Books. (2004). Person-centred catalogue: Counseling and psychotherapy books and journals. Ross-on-Wye,

Herefordshire, United Kingdom: Author. (www.pccs-books.co.uk)

RICE, L. N., & GREENBERG, L. S. (Eds.). (1984). *Patterns of change: Intensive analysis of psychotherapy process.* New York: Guilford Press.

RICE, L. N., & GREENBERG, L. S. (1990). Fundamental dimensions in experiential therapy: New directions in research. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp. 397–414). Leuven, Belgium: Leuven University Press.

ROBINSON, L. A., BERMAN, J. S., & NEIMEYER, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108,* 30–49.

ROGERS, C. R. (1942). *Counseling and psychotherapy: New concepts in practice.* Boston: Houghton Mifflin.

ROGERS, C. R. (1951). *Client-centered therapy: Its current practice.* Boston: Houghton Mifflin.

ROGERS, C. R. (1957). The necessary and sufficient conditions of psychotherapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95–103.

ROGERS, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework (pp. 184–256). In S. Koch (Ed.), *Psychology: A study of a science—Vol. 3. Formulations of the person and the social context.* New York: McGraw-Hill.

ROGERS, C. R. (1961). *On becoming a person.* Boston: Houghton Mifflin.

ROGERS, C. R. (1969). *Freedom to learn: A view of what education might become.* Columbus, OH: Merrill.

ROGERS, C. R. (1970). *Carl Rogers on encounter groups.* New York: Harper & Row.

ROGERS, C. R. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact.* New York: Delacorte Press.

ROGERS, C. R. (1980). *A way of being.* Boston: Houghton Mifflin.

ROGERS, C. R., & DYMOND, R. (Eds.). (1954). *Psychotherapy and personality change.* Chicago: University Press.

ROGERS, C. R., GENDLIN, E. T., KIESLER, D. J., & TRUAX, C. (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison, WI: University of Wisconsin Press.

ROGERS, C. R., & SKINNER, B. F. (1956, November 30). Some issues concerning the control of human behavior. *Science, 124*(3231), 1057–1066.

ROGERS, N. (2002). *A daughter's tribute* [CD-ROM]. Los Angeles: Mindgarten Media. (Available from www.mindgartenmedia.com)

ROSENZWEIG, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6,* 412–415.

RUDOLPH, J., LANGER, I., & TAUSCH, R. (1980). An investigation of the psychological effects and conditions of person-centered individual psychotherapy. *Zeitschrift für Klinische Psychologie: Forschung und Praxis, 9,* 23–33.

RUSSELL, D. (Ed.). (2002). *Carl Rogers: The quiet revolutionary—An oral history.* Roseville, CA: Penmarin Books.

RYCKMAN, R. M. (2004). *Theories of personality* (8th ed.). Belmont, CA: Wadsworth.

SACHSE, R., & ELLIOTT, R. (2001). Process-outcome research on humanistic therapy variables. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 83–115). Washington, DC: American Psychological Association.

SCHMID, P. F. (2003). *The person-centered Web site.* Retrieved November 22, 2003, from http://www.pca-online.net

SEXTON, T. L., & WHISTON, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*(1), 6–78.

SEXTON, T. L., WHISTON, S. C., BLEUER, J. C., & WALZ, G. R. (1997). *Integrating outcome research into counseling practice and training.* Alexandria, VA: American Counseling Association.

SMITH, D. (1982). Trends in counseling and psychotherapy. *American Psychologist, 37,* 802–809.

SMITH, M. L., & GLASS, G. V. (1977). Meta-analyses of psychotherapy outcome studies. *American Psychologist, 32,* 752–760.

SMITH, M. L., GLASS, G. V., & MILLER, T. J. (1980). The benefits of psychotherapy. Baltimore: Johns Hopkins University.

STUBBS, J. P., & BOZARTH, J. D. (1994). The dodo bird revisited: A qualitative study of psychotherapy efficacy research. *Journal of Applied and Preventative Psychology, 3*(2), 109–120.

Task Force on Empirically Supported Therapy Relationships. (n.d.). *Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force.* Retrieved October 28, 2003, from http://academic.uofs/faculty/Norcross/empir.htm [Web site of committee chair John Norcross]

TAUSCH, R. (1990). The supplementation of client-centered communication therapy with other validated therapeutic methods: A client-centered necessity. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp. 447–455). Leuven, Belgium: Leuven University Press.

TRUAX, C. B., & MITCHELL, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 299–344). New York: Wiley.

VANBALEN, R., LEIJSSEN, M., & LIETRAER, G. (1986). *Droom enwerkelijkheid in client-centred psychotherapie* [Dream analysis in client-centered psychotherapy]. Leuven, Belgium: Acco.

WAMPOLD, B. E. (2001). *The great psychotherapy debate: Models, methods and findings.* Mahwah, NJ: Erlbaum.

WAMPOLD, B. E., MONDIN, G. W., MOODY, M., STICH, F., BENSON, K., & AHN, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically "all must have prizes." *Psychological Bulletin, 122,* 203–215.

WILTSCHKO, J. (1994). *Focusing therapy: Some fragments in which the whole can become visible.* Retrieved September 8, 2004, from http://www.focusing.org/wiltschko.htm

World Association for Person-Centered and Experiential Psychotherapy and Counseling. (2004). *Web site of the World Association for Person-Centered and Experiential Psychotherapy and Counseling.* Retrieved September 15, 2003 from pce-world.org