The Future of Humanistic Therapy

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SYNOPSIS

Based on the book *The Problem with the Humanistic Therapies* (Totton, 2010), this article explores six questions: Is the autonomous status of humanistic therapy still important? What, if any, bridges should be built between humanistic therapy and other modalities? Are the differences between humanistic schools themselves still significant and worth preserving? What could be improved in humanistic therapy on a clinical level? What could be improved on a theoretical level? And what does the future seem likely to bring? It concludes that two futures need to be considered: the more likely but less attractive, where humanistic therapy increasingly conforms to the mainstream; and the more attractive but less likely, where it reasserts its core values.

This article is based on my recent book, *The Problem with the Humanistic Therapies* (Totton, 2010). The Problem With... is the overall title of the series, which includes volumes on psychodynamic therapy, coaching and other modalities; each book considers the positive as well as negative aspects of its subject, and ends with suggestions as to how things might move forward. In the book, I offered six questions for discussion:

- Is the autonomous status of humanistic therapy still important?
- What, if any, bridges should be built between humanistic therapy and other modalities?
- Are the differences between humanistic schools themselves still significant and worth preserving?
- What could be improved in humanistic therapy on a clinical level?
- What could be improved in humanistic therapy on a theoretical level?
- What does the future seem likely to bring?

I will explore each of these in turn.

Is the Autonomous Status of Humanistic Therapy Still Important?

There is a powerful tendency – related to, but distinct from, the drive for regulation – towards increasing integration of the various approaches to psychotherapy and counselling: an ironing out of differences, an emphasis on what we share, a simplification of the field – perhaps ultimately creating a generic occupation in which differing modalities play only a minor role. In the UK at least, this movement towards integration is driven largely by the demands of state and private managerial systems which would ideally like all practitioners to be doing the same thing, in the same way, demonstrating the same 'competencies'. The existing situation, with many dozens of schools and approaches all doing *some* of the same things, in some of the same ways, but also all diverging from each other in a variety of *different* ways, is a bureaucrat's nightmare.

Humanistic therapy is an obvious potential victim here, since it has paid less attention than other therapy modalities to clarifying and defining its unique positions in terms recognisable to administrators. This is *in itself* a reason to defend the independence of humanistic work, as a terrain where freedom is recognised as an inherent value – a powerful position worth defending, but also a vulnerable one in the current context of positivist hegemony. The state does not want to hear about the inherent truth value of each person's experience, it wants

to hear about how they can be got back to work with their symptoms alleviated.

We can seldom make absolute distinctions in the therapy world, but here are some pretty strong ones. Unlike most CBT and all medical model therapies, humanistic practice is oriented towards growth, not cure. Unlike most psychodynamic therapies, humanistic practice is *actively* relational and egalitarian. These two distinctions are key to its unique identity; if it were to be subsumed into a generic version of therapeutic practice, this is what would be lost.

The existence of different modalities and approaches benefits not only the client, but also the practitioner (which is of course therefore also good for clients, who benefit from having happy practitioners). Different clients need different approaches which best suit their problems, life situation and personality. But it is equally important for practitioners to work in a style which suits *their* personality, and hence enables them to give their best. If all the psychoanalysts were asked to do CBT, all the CBTers to do humanistic therapy, and all the humanists to do psychoanalysis, then even after retraining it is unlikely that either the practitioners or their clients would be satisfied with the result!

What, if any, Bridges Should Be Built between Humanistic Therapy and Other Modalities?

Despite the above, there is an authentic need to strengthen the interconnections between modalities, and for each to learn from the others while still recognising and preserving the real differences of approach. The humanistic therapies have plenty to learn and plenty to teach. What they have to learn is perhaps primarily about containment and restraint; while what they have to teach is perhaps primarily about spontaneity, mutuality and trust.

This doesn't describe best practice in each modality, where the finest practitioners have already incorporated all or much of what they need from the other modalities. But the average practitioner is often very ignorant of what is going on elsewhere, and not equipped to invent for themselves what is missing or under-emphasised in their own training. I will stick my neck out and say that many humanistic practitioners need to learn more restraint, while many psychodynamic and behavioural practitioners need to achieve more spontaneity and mutuality.

Humanistic therapy is rooted in an appreciation of people and their innate tendency to heal and grow; it displays a valuing of individual quirks and foibles, a principled willingness to follow where the client leads, and an optimism which is itself conducive to therapeutic success. The weaknesses which can follow from this attitude include impulsiveness, over-involvement with the client, a distrust of theory (especially if it involves 'putting people in boxes'), and a reliance on charisma. Here humanistic practitioners can usefully learn from the other models, which have evolved effective ways of stepping back from the immediate relationship and from identifying *with*, rather than just identifying, the feelings and reactions it evokes in us. This is one of the things theory is good for: it encourages us to *think*, to fit the immediate experience into a wider context, to interrogate our first impulse for what it tells us rather than immediately transform it into action.

Of course the humanistic therapies already have the tools for this sort of thinking – script theory, for example (Steiner, 1990), or Process Work's concept of 'dreaming up' (Mindell, 1987), or Gestalt's analysis of contact disturbances (Latner, 1992), or the Reichian theory of character (Totton and Jacobs, 2001: Chapter 3). Psychodynamic conceptualisations of relational issues in terms of transference and countertransference also have a great deal to offer, as is indicated by their very wide influence on humanistic and integrative work. But such frameworks are not always applied to help the therapist 'cool off' and consider the implications of their immediate responses.

The *least* useful import from other modalities is unfortunately the most prevalent: various psychopathologies and diagnostic systems are increasingly a part of humanistic practitioners' mental furniture. This stems largely from intense external pressure: the NHS on the one hand, and insurance companies and their case management offshoots on the other, demand a diagnosis if they are going to underwrite treatment – understandably, given that both institutions exist to address medical problems, and therefore need a medical definition of what is going on in therapy. Since they, alongside voluntary organisations whose funders have largely adopted the same approach, are the only sources of subsidy for therapy, this demand has largely been accepted, and therapy's heritage of medico-pathological labels has been dusted off – even though the humanistic therapies have stated over and over again that their central task is to work with growth rather than cure.

Are the Differences between Humanistic Schools Themselves Still Important and Valuable?

Like any beleaguered group, humanistic practitioners have increasingly tended towards mutual support,

huddling together for comfort and protection. This encourages 'integrative' approaches – not only between humanistic and psychodynamic theory, but between different humanistic schools. Integration fits with the overall humanistic ethos; as Eric Whitton says, 'one of the most important aspects of humanistic therapy is that it is inclusive rather than exclusive' (Whitton, 2003: 38).

However, humanistic therapy can resemble the Church of England: if inclusiveness is a strength, woolliness is a corresponding weakness. A united front between modalities which share values does not mean that they are interchangeable. There are significant differences between the humanistic therapies, philosophically, theoretically and clinically; and these will be experienced by clients primarily as differences of atmosphere. A 'typical' Rogerian therapist, for example, will be accepting, letting the client set the pace and content of the work; while a 'typical' Transactional Analysis (TA) therapist will lay out their stall to a greater or lesser extent at the start of the work, explaining to the client how TA works and how it understands people. A 'typical' Gestalt therapist (and in each modality many practitioners are not typical) will focus on style more than content, challenging the client to track their immediate experience and how they process it. All roads lead to Rome, but these are three very different directions to start out in! There are also humanistic therapists who work primarily with embodiment, or different forms of creative expression, or in some self-developed individual style.

What Could be Improved in Humanistic Therapy on a Clinical Level?

My suggestions here cluster around issues of relationality and unconscious process. Humanistic practitioners tend to overplay the role of consciousness and intention in therapy: the only aspects of relationship to be explored may be those available to immediate awareness. To go further into 'relational depth' (Mearns and Cooper, 2005), alongside the positions of client and therapist there needs to be present the third position of witness, fostered by external and internal supervision.

A strength of humanistic therapy is its culture of ongoing clinical supervision. It is regarded as a norm, and enforced by many organisations, that practitioners at every level of experience have supervision on their client work. 'The basic humanistic position is that all therapists need supervision all the time' (Rowan, 1998: 192). In my view this is very valuable, contrasting with the much more ambiguous role of supervision in psychoanalytic work, where 'needing supervision' can be regarded as a sign of clinical immaturity, to be replaced with ad hoc 'consultation'; and also with many employment contexts where line management competes with or replaces clinical supervision. However, there are far too many humanistic practitioners with questionable supervision arrangements. I still encounter therapists whose supervision is part of their personal therapy! Short of this extreme of potential collusiveness, some humanistic supervision styles seem designed to protect the therapist's ego more than their clients. There are some very useful books on humanistic supervision (Proctor, 2000; Page and Woskett, 2001; Hawkins and Shohet, 2007), which need to be widely read and applied.

But what of the *internal* supervisor? This concept was developed by Patrick Casement (1985, 1990), who sees it as 'more than self-analysis and more than self-supervision', based in an essentially playful capacity to identify with the client and with other people whom the client mentions, and to synthesise these points of view along with one's own (ibid.: 34ff). For example, if the client talks of being angry with a friend, the internal supervisor muses that 'someone is angry with someone' (ibid.: 38), rather than being drawn into the soap opera plot. Although I have serious criticisms of how Casement carries out this project in practice (Totton, 2000: 144–5), his theoretical account is exemplary, and feeds into the recent 'relational turn' in psychoanalysis (Greenberg and Mitchell, 1983; Mitchell and Aron, 1999). This has been paralleled in several other psychotherapy modalities (e.g. Hargarden and Sills, 2002; DeYoung, 2003; Dworkin, 2005; Mearns and Cooper, 2005; Spinelli, 2007).
One of the exciting aspects is that it brings together psychodynamic and humanistic practitioners, including body psychotherapists, who all agree that relationship is at the heart both of people's problems and of the solutions to those problems. The humanistic tradition has much to contribute to relational psychotherapy, having always emphasised what radical analysts are calling the '"now" moment' in therapy, when the practitioner has to abandon theory and respond from their own authenticity (Boston Change Process Study Group, 1998, 2003).

Humanistic practitioners, one might say, have always specialised in *leaning forward* – offering warm human contact to the client, being interested in and committed to their process and willing to offer themselves to the relationship. The analytic tradition is now recognising the value of this aspect of the work. But in order to make the best use of these strengths, humanistic therapists

perhaps need to learn more about *leaning back*, creating an internal space for thinking and fantasising about what is going on with and for the client, in parallel with being part of that process. This does not necessarily involve the sort of interpretation of which many humanists are suspicious. At the most basic, it is a resource for our own authentic relating.

What Could Be Improved in Humanistic Therapy on a Theoretical Level?

This internal space of leaning back is, of course, the space of theory itself, where we think *about* the world rather than simply being part of it. I believe theory is underdeveloped in humanistic therapy: in integrating body, mind, spirit and emotion, mind is too often the poor relation. There is plenty of what passes for theory; but much of it strikes me as verbiage, a windy rehearsal of the obvious and the dubious with little bearing on the practice of therapy. Humanistic therapy has Big Ideas in plenty; it also has a lively and powerful clinical practice. What seems in relatively short supply is a method of connecting the two. Those who teach the modalities of humanistic therapy may be surprised and offended by this statement; but if they lean back rather than forward, they may see some truth in it.

TA, in particular, has no philosophical overview: all of the many, often elaborate concepts are essentially operational, ways of *describing* rather than *explaining* what happens. Stewart and Joines say quite explicitly that 'an ego-state is not a thing. Instead it is a name, which we use to describe a set of phenomena' (Stewart and Joines, 1987: 18). But the same applies to any noun – 'tree' or 'mountain', say; and this does not remove the responsibility to make coherent sense of the names we use and their relationship with other names. Without theories of internalisation and projection, for example, ego-states (Parent, Adult and Child) are mysterious and inexplicable. They also contain imported and unexamined theories of human nature and development. TA places too high a priority on being easy to understand (Stewart and Joines, 1987: 8): some realities (quantum mechanics, for instance, or human consciousness) are inherently not easy to understand!

Gestalt Therapy does indeed rest on a set of philosophical positions. In fact, there are perhaps rather too many of them. Perls identified phenomenology and (a little surprisingly) behaviourism as the key philosophies behind his work; existentialism, field theory, and of course gestalt psychology are also often mentioned, while the trace of psychoanalytic ideas is everywhere present but scarcely ever referred to. Gestalt has perhaps still to achieve a maturity where its emphasis on here-and-now awareness can articulate fully with its intellectual position. Instead, it trails a bag of theories behind it – a bag which may even be the unintegrated shadow of its insistence on immediate experience.

The essence of Rogerian theory can be – and has been – written on one side of a sheet of paper: the 'six conditions for therapeutic change', or even more so the three 'core conditions', are very brief, but their unpacking takes a lifetime. As Pete Sanders puts it, the conditions for therapeutic change are 'attitudes not skills' (Sanders, 2006: 9) – what Amy Mindell (2003) calls 'metaskills', in some ways close to what we used to call 'virtues'. So there is a certain incongruity in the elaborate theoretical structures which have been built on this foundation; at its best, Rogerian work is the Quakerism of psychotherapy, concerned with presence, not theology.

I suspect that if the humanistic therapies are to transcend their theoretical limitations, they will need to take the courageous step of letting go of their inherited language and terms of reference, and reinventing themselves from the ground up: a difficult and frightening move for any institution, and especially hard at a moment when humanistic therapies are so much on the defensive back foot.

What Does the Future Seem Likely to Bring?

We are experiencing a powerful trend, in therapy and in Western society generally, towards regulation, monitoring and control of all activities. This is often justified by appealing to two goals: security and effectiveness. People must be protected, it is argued, from the incompetent and the ill-intentioned; therefore all activities must be conducted in ways which 'expert' opinion deems to be effective and safe, and everyone who carries them out must be trained and tested for competence in following these safe and effective methods.

Although the attempt to regulate therapy as a form of medical practice has, for now, been defeated, the state's involvement in the future of psychotherapy is wider than this. It has committed itself to a major investment in training and deploying practitioners in the public sector. However – in line with the ideology of expertise and 'evidence-based practice' – it has been persuaded to privilege Cognitive Behavioural Therapy over both psychodynamic and humanistic approaches.

The humanistic therapies may be handicapped in their principled opposition by twin Achilles' heels: their hunger for recognition, and their desire to be of use. Currently, energy which might have gone into opposing oversimplified notions of evidence-based practice is being used to campaign for continuing recognition of humanistic therapy within the National Health Service; while a whole range of humanistic training organisations have hurriedly organised bolt-on courses in CBT. This can only dilute and disguise the real point of humanistic therapy, which is *'therapeutic personality change'* (Rogers, 1957) – transformative movement in the whole structure of the human being, rather than the alleviation of specific symptoms.

So we can talk of two futures: the more likely but less attractive, and the less likely but desirable. The less attractive future involves an increasing conformity to the social mainstream, and the loss of much of what makes humanistic work valuable, so that these modalities eventually continue only as shells. The desirable future, I suggest, is one in which humanistic practitioners and organisations reassert the principles on which their tradition is based: recognition of the client's inherent tendency to grow, respect for the client's inherent intelligence and autonomy, and integration of the different aspects of being human. At least for now, these are minority values; but the minority can often exercise a crucial influence on the mainstream.

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