The Person-Centered Approach in Germany: To Cut a Long Story Short

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Abstract. This article outlines the history and development of client-centered therapy in Germany against the background of the evolving professionalization of psychotherapeutic care. Representatives of the approach had neglected to assert their interests in health policies for years. As a consequence, client-centered therapy (CCT) failed to achieve a secure position within the German medical care system, which de facto led to the exclusion of CCT until now. The resulting practical consequences for client-centered psychotherapists and training activities are exemplified. Finally a critical analysis investigates if traits inherent to the person-centered approach have provoked the described situation. Proposals for the future of CCT in Germany are discussed.

Keywords: client-centered therapy, person-centered approach, German health system, historical development of the PCA in Germany

Der Personzentrierte Ansatz in Deutschland – um es kurz zu machen
Der Artikel skizziert die Geschichte und Entwicklung der Klientzentrierten Psychotherapie in Deutschland auf dem Hintergrund der sich entwickelnden Professionalisierung der psychotherapeutischen Versorgung. Vertreter des Ansatzes haben es versäumt, ihre Interessen gesundheitspolitisch so zu behaupten, dass es der Klientenzentrierten Psychotherapie gelungen wäre, sich berufspolitisch sicher in den Organisationen des Gesundheitswesens zu positionieren. De facto wurde damit die Klientenzentrierte Psychotherapie offiziell ausgeschlossen. Die Konsequenzen, die sich daraus für PsychotherapeutInnen und Ausbildung ergeben, werden praktisch nachvollziehbar dargestellt. Es wird kritisch zu prüfen sein, ob dem Personzentrierten Ansatz inhärente Merkmale die geschilderte Situation mitbedingt haben. Daraus lassen sich Anregungen für die Zukunft der Klientenzentrierten Psychotherapie in Deutschland ableiten.

El enfoque centrado en la persona en Alemania: Resumiendo una larga historia
En este artículo se describe la historia y desarrollo de la psicoterapia centrada en el cliente en Alemania con el telón de fondo de la evolución de la profesionalización de la asistencia psicoterapéutica. Durante años los representantes del enfoque no pusieron énfasis en hacer valer sus intereses en las políticas de salud. Como consecuencia la psicoterapia centrada en el cliente no logró asegurar una posición firme

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dentro del sistema alemán de atención médica, lo que, de facto, llevó a la exclusión de la psicoterapia centrada en el cliente hasta el presente. Mostramos las consecuencias prácticas para los psicoterapeutas centrados en el cliente y para las actividades de formación. Finalmente un análisis crítico investiga si rasgos inherentes al enfoque centrado en la persona han provocado la situación descrita. Discutiremos propuestas para el futuro de la psicoterapia centrada en el cliente en Alemania.

Une courte histoire de l'approche centrée sur la personne en Allemagne
Cet article résume l'histoire et l'évolution du développement de la Psychothérapie-Centrée-sur-le-Client en Allemagne dans le contexte de la progression de la professionnalisation du soin psychothérapeutique en parallèle. Pendant des années, les représentants de l'Approche avaient négligé de faire connaître leur intérêt pour la politique de santé. Il en a résulté que la Psychothérapie-Centrée-sur-le-Client n'a pas su s'assurer une position forte dans le système allemand de soins médicaux, entrainant jusqu'à maintenant, l'exclusion de la Psychothérapie-Centrée-sur-le-Client. Dans cet article, les conséquences pratiques concernant les psychothérapeutes et les formations centrées sur la personne sont présentées en détail. Finalement une analyse critique cherche à découvrir si des traits inhérents à l'Approche Centrée-sur-le-Client ont provoqué cette situation et des pistes pour l'avenir de la Psychothérapie-Centrée-sur-le-Client sont proposées et discutées.

A Abordagem Centrada na Pessoa na Alemanha: Breve resenha
Este artigo ilustra a história e o desenvolvimento da Psicoterapia Centrada no Cliente (PCC) na Alemanha, destacando-a do panorama de profissionalização emergente dos cuidados psicoterapêuticos. Os representantes da abordagem negligenciaram durante anos a sua afirmação no âmbito das políticas de saúde. Consequentemente, a PCC não conseguiu assegurar uma posição sólida no seio do sistema de cuidados médicos alemão, o que, de facto, conduziu à exclusão da PCC até hoje. São exemplificadas as consequências práticas para os psicoterapeutas centrados no cliente e para as actividades de formação. Por último, uma análise crítica explora se terão sido as características intrínsecas da PCC que provocaram a situação descrita. Serão discutidas propostas para o futuro da PCC na Alemanha.

ドイツにおけるパーソンセンタードアプローチの現状

The person-centered approach (PCA) was brought to Germany in the 1960s and soon found widespread acceptance in psychotherapy, counseling and education, and became the subject of research programmes at universities. Rogers' idea of a democratic society, the equality of human beings, the focus on individuality and relatedness, and his vision of a humane and peaceful society helped people to meet the challenges of change from the norms of Nazi Germany into all aspects of today's democratic society (Rogers, 2002; Schmid, 1996). This clearly was very important for and in post-war Germany. In spite of its acceptance in all aspects of society this was not reflected in an appropriate institutional anchoring.

This article describes the positioning of client-centered therapy (CCT) within the German health system during the professionalization of psychotherapy. This history is closely intertwined with the introduction of legislation to anchor psychotherapeutic care, which will be described first. The long story of the development of CCT in Germany will then be contrasted against this background. The consequences for psychotherapists will be outlined and illustrated by the case of a client-centered training institute. The present situation of the PCA in Germany will finally be evaluated with respect to the potential for further development.

The comments refer to the PCA in Germany only. Other German-speaking countries such as Austria, parts of Switzerland and France are not represented as Europe has not amalgamated sufficiently to allow for such statements.

PSYCHOTHERAPY IN THE GERMAN HEALTH CARE SYSTEM

Medical care in the Federal Republic of Germany, including the provision of psychotherapy, is carried out within the framework of health policies legislated by parliament. The German system of psychotherapeutic care offers insurance services for the population ("statutory insurance") with free access to psychotherapy, which places it in a unique position internationally. These laws apply to the majority of German insurees (approximately 90%; Statistisches Bundesamt, 2006); only a minority of the population with high income are allowed to insure themselves with private insurers who are not part of the system outlined above. In "statutory insurance" the insuree and his or her family are covered by the policy for a low charge, and employers pay a considerable proportion of the insurance rate. German insurees are used to a high standard of medical and psychotherapeutic care which normally they do not have to pay for outside their statutory insurance rate. The Organisation for Economic Cooperation and Development (OECD) illustrates this fact: Compared to other countries, in 2004 Germans spent an average of US$3,300 for health, while, e.g., US citizens spent US$6,400. At the same time, the proportion of communal health spending in both countries was almost identical, spending US$2,800 per person (Rabbata, 2007).

Germany experienced a peaceful reunification of the two German states in 1990. Prior to that time, psychotherapy was included in the social insurance system of the German Democratic Republic (East Germany) (Kommer & Wittmann, 2002). The former West German state provided outpatient psychotherapy by medical doctors or other psychotherapists with at least three years of academic training. If clients chose nonmedical psychotherapy, applicants were required to get approval through their insurance company's medical service. The statistics of the federal association of medical practitioners in the health insurance system (Kassenärztliche Bundesvereinigung) in 2006 list the methods used in that procedure in 1987: 55% of the cases were treated with CCT; 48% each with psychodynamic and (cognitive) behavior therapies; 29% with family therapies; 28% with gestalt; and 22% with psychoanalytic therapies. In this survey, multiple nominations were allowed in order to account for multimodal treatments. CCT clearly was the most prominent (see Hentze, 2006, 2007). In parallel were psychotherapists working under the auspices of medical doctors with a psychotherapy training,

being payed through the medical health insurance system ("Delegationsverfahren" Waldherr, 2003). Schildt (2007) reports of 6700 therapists working in this way.

During that time (from 1980) most of the outpatient psychotherapy in West Germany was carried out by psychologists. They (mostly female) had predominantly been trained in and were using humanistic psychotherapy methods, mostly CCT or gestalt (Frohburg, 2007). Many had also obtained a qualification in (cognitive) behavior therapy, but only a few used it exclusively, as documented in a survey by Kindler et al. (1997, cited in Vogel, 1999) concerning clinical training of psychologists (n = 3.653, 42% rate of return): 38% of the respondents had been trained in CCT; 34% in (cognitive) behavior therapy; 22% in gestalt; 21% in systemic family therapy; 18% in body-oriented methods; and 16% in psychoanalytic methods. This demonstrates that to a great extent CCT was used within integrative psychotherapy. This mode of treatment has been postulated for the future, amongst others by Lietaer (2007).

The German reunification in 1990 required jurisdiction for the "implementation of psychotherapy into the health care system," which was enforced through the "Guidelines for Psychotherapy." This legislation came into force on January 1st, 1999 (legislation for psychological psychotherapists and psychotherapists for children and youths: PsychThG, Bundesministerium der Justiz, 1998). The legislation stipulates that only medical doctors and psychologists with a postgraduate training in an "approved" method of psychotherapy (see below) may carry out adult or child and youth psychotherapy after receiving their license. The latter may also be treated by academic social workers and educators who have been licensed based on the same procedure. This is mandatory within the framework of the "statutory health insurance" companies. The guidelines for psychotherapy "are supposed to ensure that all insurees will be cared for in a qualified and adequate way, while at the same time an economic use of the insurees' community's resources is effected" (Frohburg, 2007, p. 10, translation by the author).

Psychotherapy in this legislation is defined as a treatment for dysfunctions which are classified by the *International Classification of Diseases, 10th Revision* (ICD-10) according to the World Health Organization (WHO, 2001).

Clients may choose their therapist and the kind of therapeutic approach freely, but limitations are set by approved therapy hours for a specific method. Furthermore, the legislation (PsychThG) approved only three psychotherapeutical methods as "methods according to the guidelines": analytical therapy, psychodynamic therapy, and (cognitive) behavior therapy. Only these treatment methods will be paid for by insurers after a consultant's approval of an application. Private insurance companies have also adopted these standards. The inclusion of further therapeutic approaches is restricted by a number of aspects of the legislation which, in addition, have been changed several times since (Frohburg, 2007). This has led to the exclusion of additional therapeutic approaches up to the present, especially those of humanistic provenance. CCT was excluded by reason of insufficient empirical research studies (particularly randomized controlled studies) concerning its efficacy and its applicability to a diversity of mental illnesses. Advocates of the approach, however, point out the empirical evidence of the effectiveness of CCT, as Frohburg (2004) sums up: "Today one can say definitely that CCT

is an effective method of psychotherapy with a relatively broad spectrum of indicators" (p. 321, my translation).

A distinction between counseling (e.g., PCA), which is to be financed by communal organizations, and psychotherapy (e.g., CCT) to be financed by insurance companies, be they private or "statutory," has been defined at this point.

The implementation of the psychotherapy legislation brought legal and safety liability and professionalization to medical and psychological psychotherapists. The legislation thereby fullfilled the duty to provide highly qualified treatment which is also cost effective. On the other hand the legislation led to a professional ban on those psychotherapists who had been trained only in humanistic psychotherapy methods. Many colleagues had to requalify in "methods according to the guidelines" to adapt to the new conditions and to go on working (Heisig & Littek, 2003). The legislation obviously prohibited insurees from choosing methods which had been widespread in the outpatient and inpatient health system in the past and enjoyed an approved scientific status internationally. This was especially true for CCT (Frohburg, 2004). The pervasiveness of CCT in health care institutions was demonstrated by Kriz (1999): According to the insurance companies, since 1987 some 10,000 patients had been treated in health care institutions using CCT. Only outpatient psychotherapy treatment is being regulated in the way outlined above. Counseling services in other parts of the community (education and family, drug abuse, theology, conflict management, etc.) may offer PCA without legal limitations.

SUMMARY OF THE HISTORY OF CCT IN GERMANY

Anne-Marie and Reinhard Tausch promoted the establishment of PCA in West German academia in the 1960s under the title of what can literally be translated as "talking therapy" ("Gesprächspsychotherapie," Tausch & Tausch, 1968). In East Germany Frohburg (1995) and Helm (1978) served as pioneers. Numerous other academics taught the PCA or CCT at universities, advanced empirical studies, and developed the approach further (Eckert, 2001; Kriz, 2004). In the mid-1990s three-quarters of the psychological institutes at German universities offered CCT (behavior therapy 84%), while 60% taught practical competences as well (Frohburg, 2007) and generated a multitude of studies concerning the efficacy of CCT.

In 1970, the "Gesellschaft für wissenschaftliche Gesprächspsychotherapie" (GwG – association for scientific counseling and psychotherapy in the PCA) was founded, which established the PCA through the development and application of training programs for skill enhancement and further education in psychotherapy and counseling, thereby supplementing academic education. Most of the GwG's members attended these as postgraduate trainees prior to or during their membership.

GwG represents and promotes the PCA in practice, research, science, and politics. It is the biggest European professional association for psychotherapy and counseling with a membership of about 4,000 in 2008. Of their members, 65% have graduated in psychology

with an academic diploma at the level of a master's degree, 12% are social workers, the rest come from other professions (GwG, 2006; see Figure 1). Within the organization more than 200 members have acquired teaching status for counseling and/or psychotherapy. They administer PCA training and studies as well as quality management and professionalization (supervision and intervision [highly qualified participants] groups and trainers).

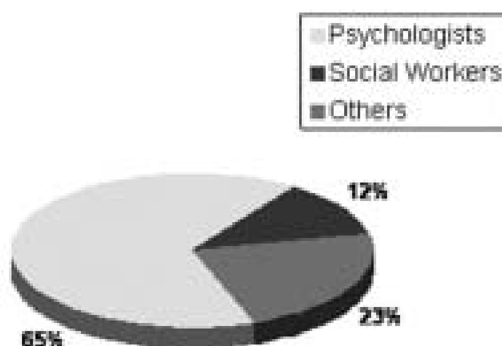

Figure 1. Professions of 4,000 GwG members

The GwG today engages in influencing legislation concerning CCT in Germany, to promote the licensing of client-centered psychotherapists. It also contacts and cooperates with other national and international associations for the PCA, networking to bring together PCA professionals. It supports research and publications, e.g., the PCE 2006, 7th World Conference for Person-Centered and Experiential Psychotherapy and Counseling was held in Potsdam, Germany. The GwG grew from a number of volunteering pioneers into an active representative of interests with an employed managing director and staff. But although the organization today appears to be powerful, based on the number of members, and new energy was brought in by the integration of our East German collegues, its impact on health policies has not been as powerful as one would expect. In fact, during the last 30 years an ongoing battle for the integration of CCT into the German health system has had to be fought. To cut a very long story short, Henze (translated by the author) summed it up in June, 2006: "Are we facing a legal development of the PCA [in Germany] which is a comedy, a tragedy, a game of chess, a criminal story, a political power play or the abuse of democratic institutions?" His data demonstrate that since 1967 the development of the PCA has been politically driven. One side consists of professional associations (including GwG) who want to practice the PCA or CCT within the structures of the society as a "method according to the guidelines." The opposition consists of different interest groups, mainly representatives of organizations of the medical professions, of health insurance providers, and of competing therapeutic methods, who are afraid of a cost explosion. Representatives meet in diverse committees during the

democratic process to formulate the new legislation. The majority decisions of one committee are later opposed by the decisions of another committee with a different majority. The situation was aggravated when the 1999 psychotherapy legislation left an opening for future approaches to be certified as acceptable (gestalt, CCT and others have to apply for this status) but ratified the already accepted psychotherapies, with the consequence that CCT was again excluded by legislators. On the one hand, time and again (1967, 1972, 1978, 2002) CCT has been acknowledged by different committees as a scientifically proven psychotherapy. In addition, in 1998, 80 German professors from the fields of psychotherapy and clinical or medical psychology campaigned for the incorporation of the scientific community's opinion that acknowledged CCT as "a practiced and approved method" (Frohburg, 2007, p. 45, my translation). Furthermore, legal status was given to institutes for postgraduate training in CCT in 2002, thereby providing the prerequisite to include CCT into the system of health insurances. One would think that all obstacles would then have been overcome. On the other hand, the committees and agents promoting CCT do not have any legislative power. This is given to a council called "Gemeinsamer Bundesausschuss" (G-BA). G-BA defines which treatment methods are or will be included in the catalogue of benefits of the statutory health insurance companies. It is supervized by the federal ministry of health. In 2007, the G-BA vetoed the inclusion of CCT into the health insurance system, questioning the efficacy of the method. It rejected 423 of 424 reports of research data by acknowledged academics that show the efficacy of CCT (Eckert, 2007). One can speculate that the reasons are mostly political and not scientific. This bickering not only keeps professional politics and lobbies busy, but, since 1972, the courts as well (Eckert, 2007; Frohburg, 2007; Mrazek, 2007) in very complicated, specialized and seemingly endless lawsuits.

Tragically in this long story, the support of the established national legal chamber for psychotherapists (Bundespsychotherapeutenkammer) has not been as effective or recognized as it should have been (Cramer-Düncher & Hentze, 2007). The same is true for the efforts of WAPCEPC.

The consequences of this situation are very serious. CCT will not be included in the health system in the foreseeable future, which equates to a professional ban for the many experienced client-centered therapists. They do not have an independent legal status. Currently client-centered therapists can be licensed within the system of health insurance companies only under the accepted labels of "psychodynamic" or "(cognitive) behavior therapy" if they also meet the criteria for these approaches. According to Frohburg (2004), this only accounts for approximately 1,300 client-centered therapists, who have obtained a license to practice in one of the statutory "methods according to the guidelines." For the German population this exclusion of CCT implies that it is ineffective. The predominant status that the PCA has enjoyed in the area of counseling has been severely damaged during this process as well.

Furthermore, this unfortunate outcome has led to a neglect of the PCA in academia, research, training of future professionals, and in the application of the method in respected inpatient settings of high standing. Today 80% of the professors in clinical psychology at German universities are behavior therapists, and influence the psychotherapeutic orientation of their students. In a survey by the University of Cologne more than 50% of the students

with a preference for (cognitive) behavior therapy said they had not been informed sufficiently about other therapeutic methods (Eichenberg, 2007).

THE POLITICAL IS ALSO THE PERSONAL: AN EXAMPLE

In the following, the effects of the described developments will be illustrated by my personal workload:

I earn my living in my practice as a licensed behavior therapist by seeing up to eight clients every day, nine months of the year. My professional freedom allows me, however, to use my own judgment in treatment once the number of therapy hours has been allocated by the consulting assessor. I enjoy cooperating with the University of Heidelberg in the postgraduate training of students with a master's degree in psychology, who are being trained to become licensed behavior therapists.

Congruent with my own conviction, I have been a trainer for psychotherapists and counselors in the PCA with GwG since 1980. In this position I have trained 324 students up to now. These programs consisted of 300 study hours over a period of two years.

In addition, I founded the Institut fuer Personzentrierte Psychologie (IPP), Heidelberg, a nonprofit organization, in 1985, of which I have been a director ever since. This was stimulated through the work I was privileged to share with Carl Rogers during the last years of his life. We cooperated on Cross-Cultural Communication workshops and international training activities, even before the Iron Curtain fell. Rogers was convinced that the PCA is more "a way of being" than a collection of intervention methods. The GwG, however, at that time was not interested in building international networks on these foundations. Therefore an international informal group of up to 20 members teamed up in IPP and trained 98 students in counseling and psychotherapy. These programs were funded by the German labour administration, which required the programs to be administered within two years. The participants had to master a workload of 1,600 study hours in addition to fieldwork. Changing laws stopped this support. After this, we extended the training to three years. As the development of our trainees called for changes in their self-concept and in-depth learning, the majority of them underwent five years of training with 2,000 study hours. Some students had previously graduated from the GwG basic training, bringing the duration of their active studies and commitment to seven years. Within this format we actively supported Cross-Cultural Communication workshops, i.e., encounter groups of up to 250 participants from 18 or more nations all over Europe. We also arranged common training experiences for students from different countries in national or international settings.

Figure 2 outlines my personal GwG and IPP activities. The horizontal axis marks the year, while the vertical axis shows the number of participants. One can see that the rate of attendance dropped dramatically in both settings around the time when the discussion to exclude CCT from the psychotherapy legislation became prominent: The upper graph shows the GwG participants, dropping from a peak of 56 in 1994 to 16 in 1996. The lower graph demonstrates the IPP students, dropping from a peak of 18 in 1992 to 6 in 1994. To have

IPP groups at all we added newcomers to existing groups, with a constant decline in participants. The same is happenening to GwG groups at present. Today a total of only 11 students in both settings remain, which allows me to maintain my competence. Our yearly encounter group in Greece had to be cancelled in 2006 for the first time in eight years due to a lack of participants. We can no longer afford international cooperation.

The decrease of *my* work load as a trainer exemplifies the general situation for PCA activists: In the vicinity of Heidelberg previously 14 GwG trainers had been active. Now most of them are out of that job. Even though new courses are being offered here and throughout Germany as well, trainees have to travel all over the country (which is unusual for German habits) because very few new groups come into existence. A vicious circle, which CCT faces, is reflected here: CCT is mentioned at German universities, but not represented to a great extent, and students are not thoroughly informed about the benefits of CCT. Moreover, as it is not acknowledged as a statutory treatment by the health insurance agencies, future psychotherapists enter training programs of other theoretical directions which lead to a seemingly more rewarding professional situation.

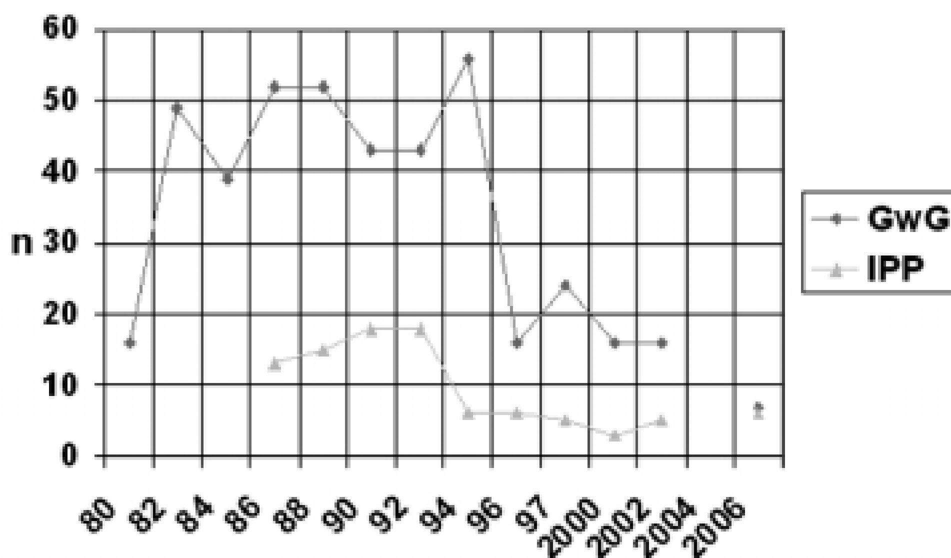

Figure 2. Distribution of GwG and IPP trainees in the IPP from 1980 to 2006

DISCUSSION

The political efforts to develop CCT in Germany as a statutory method within the medical health system, giving psychotherapists the security of professional licensing, has been described. Figure 2 outlines the effects of these developments on CCT teaching activities. From this, the question of what the future holds for the approach in Germany has to be raised.

Amazingly Carl Rogers (1981, p. 1) in his article "Some Unanswered Questions" seems to reflect not only his experiences with American health providers, but also to anticipate important developments which were to come in Germany. He stated that the PCA has been "relatively unsuccessful in changing organizations and institutions. Our successes in this … are definitely modest." And he asked how the PCA can "relate to a national … political process." GwG for many years was an association of pioneers with little interest in lobbying, trusting in the goodwill of power strategists. In congruence with the approach, it was open to differing theoretical approaches and a multitude of interest groups. With hindsight this weakened the representation of a clear identity of CCT in the political process. Today this seems politically naïve. In his article Rogers (1981, p. 4) posed the following questions concerning the assertion of power: "Is this approach, in which persons are trusted and the basic nature of man is regarded as constructive, and the emphasis is on openness, sharing and goodwill – is this approach doomed to be overwhelmed by those who believe in aggressive domination by power? … Is this also to be our fate? Does our focus on the individual reduce the likelihood of social consciousness and social change?" We have to ask ourselves if the zeitgeist of the 21st century rejects liberal positions, which stress autonomy and responsibility in favour of a need for structure, backing and advice.

Empirical psychotherapy research has found enough evidence to verify that the quality of the relationship between client and therapist, independent of the applied therapy method, is the most important and indispensable factor of efficacy and predicts the outcome of a therapy (Perrez & Baumann, 2005). Even though the three classical basic conditions of therapeutic change postulated by Rogers (acceptance, empathy and realness) are regarded to be a *conditio sine qua non* of almost all other therapeutic methods as well (Schulz, 2000) critics of CCT try to establish CCT as a functional behavior to enhance communication within one of the statutory psychotherapy approaches, but not as a sufficient therapy in its own right. They demand, moreover, that CCT should develop treatment procedures or plans which can be objectified, even manualized, and verified through randomized controlled trial (RCT) studies. For these academics and practitioners the variety of approaches within CCT (which decidedly have not been a subject of this paper), the absence of a theory to explain the development of specific psychological diseases, and in consequence the lack of specificity of treatment procedures for a labelled illness constitute the inferiority of CCT.

This evaluation belittles the foremost differentiation of CCT from other methods, i.e., the hypothesis that psychotherapists may trust their clients to find creative solutions for difficult life situations because of their actualization tendency: "We have endeavored to function in relationships on the basis of an open expression of feelings, working through differences. The stress on the self and the individual, the emphasis on individual freedom and choice …" (Rogers, 1981, p. 3), resulting in a personal encounter of the qualitative kind which CCT requires, *is* the healing process, the relationship *is* psychotherapy (Schmid, 2005, 2006). This is unique to the method of CCT.

CCT within the system of health care will have to adapt to a biopsychosocial model of diseases within a medical framework. Psychotherapists in Germany have to accept the *ICD-10* as a "common language" for professionals. The descriptive value of these

classifications does not contradict an understanding of a person's needs in an I–Thou relationship. More efforts to adapt to a medical model concerning the development or onset of psychological disorders, and consequently to specific treatments, which are disorder-oriented and not person-centered, however, will weaken our position. They seem to be as inadequate as a manualization of treatment procedures. It seems to be more promising to address the question of how the PCA in its variety can find an identity which allows for its recognition by outsiders (Schmid, 2008, personal communication). Clarifying the uniqueness of CCT would help us to stand our ground with the emphasis on being different, not having to be better than others.

Rogers outlined the resources people possess to cope with difficult life events, which challenge their self-concept or construction of the world. Theoretically, the help and support an individual might need in concrete life situations or matters of disease differ only by degree and do not suggest a separation of psychotherapy from counseling. The societal structures which have emerged in Germany, however, have encouraged diverging professional fields, with "psychotherapy" being administered by licensed psychotherapists according to the definition of mental illness as outlined in the *ICD-10*. Counseling, however, up to now is not legally regulated and may be offered by counsellors with a sound scientific background or by anybody who feels he or she can offer it. We have to accept this. If we want the PCA to have a standing of its own in today's society, and if we want CCT to be part of the German health system and not fall into oblivion, we have to go forward.

This article has been written to make known the current conditions in Germany and elicit solidarity within an international field. Political developments have fostered a tremendous waste of talent and experience, and as a consequence the PCA is gradually and increasingly disappearing from sight. We are already missing a whole generation of PCA professionals. The GwG has learned its lesson. Today it forwards the interests of client-centered professionals with clarity. International cooperation would empower those persons who muster the courage to stand up for a political position on our behalf, and also be beneficial to our training activities. Looking towards the future we should assert our national interests, because they might have a pilot function. Meanwhile, as from October 2009, CCT has been abolished from outpatient services in the German health care system altogether. A further exclusion of CCT is to be expected, if the process of the unification of Europe requires the development of common health care structures.

Personally I hope for trainees who are open to the depth the approach has to offer and are willing to spend time and resources swimming against the political mainstream. Theoretically and pragmatically I hope for a future in which the multitude of the PCA widens towards not only a coexistence but, moreover, an integration with other (directive) psychotherapy methods, for the benefit of clients. Our ambition has to be to help as many persons as possible to empower themselves through healing relationships, which will allow for more relatedness and better relationships in the world. Making use of diversity would help us to enjoy the variety and richness of life.

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