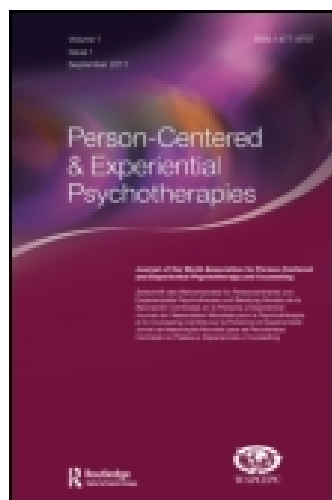


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ARTICLES

The politics of the helping relationship: Carl Rogers' contributions

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This paper highlights the present day value of Carl Rogers' many contributions. It argues that we should understand psychotherapy paradigms as value-laden social constructions that reflect predominant sociocultural biases, often creating an excessive power differential between therapist and client. Person-centered and experiential practitioners are encouraged to contribute to the larger discourse concerning the helping professions and to take the opportunities offered by the growing field of health promotion, which is person-people-community-centered.

Keywords: person-centered and experiential therapy; values; social construction; power differential; empowerment; professional politics; health promotion

Die Politik der helfenden Beziehung: Carl Rogers' Beiträge

Dieser Artikel unterstreicht, wie wichtig zahlreiche seit den 40er Jahren erschienene Beiträge von Carl Rogers heute noch sind. Er will Bewusstsein schaffen dafür, dass psychotherapeutische Paradigmen wert-geladenene soziale Konstrukte sind, die vorherrschende soziokulturelle Befangenheit widerspiegeln. Dabei schaffen sie oft große Machtgefälle zwischen Therapeuten- und Klienten-person. Personzentrierte und experienzielle Praktiker werden ermutigt, zum weiteren Diskurs der helfenden Berufe beizutragen. Sie mögen Gelegenheiten im Feld der Gesundheitsförderung nutzen, welche in einer Person-Gruppe-Gemeinwesen-zentrierten Perspektive wurzeln.

La Política de la Relación de Ayuda: Contribuciones de Carl Rogers

Este escrito resalta el valor actual de muchas aportes de Carl Rogers, que empezaron en los 40. Promueve la conciencia de los paradigmas de psicoterapia como aportes cargados de valor social que reflejan los prejuicios socio culturales predominantes, a menudo creando excesiva diferencia de poder entre el terapeuta y el consultante. Se alienta a los profesionales centrados en la persona y experienciales a contribuir a un discurso más amplio con respecto a las profesiones de ayuda y a aprovechar las oportunidades que se ofrecen en el cada vez más amplio campo de la promoción de salud, que está basado en una perspectiva centrada en la persona y la comunidad.

La Politique de la Relation d'Aide: les contributions de Carl Rogers

Cet article souligne la valeur toujours actuelle des nombreuses contributions de Carl Rogers depuis les années 1940. Il met en avant une conscience des paradigmes de la psychothérapie en tant que constructions sociales porteuses des valeurs et des biais socioculturels qui prédominent, qui créent souvent un

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différentiel de pouvoir excessif entre thérapeute et client. L'auteur encourage les praticiens centrés sur la personne et expérientiels à contribuer au débat élargi concernant les professions d'aide, et à peser dans le domaine de la promotion de la santé qui est en pleine croissance et qui est fondé sur une perspective centrée sur la personne, centrée sur les gens, centrée sur la communauté.

A Política da Relação de Ajuda: Os contributos de Carl Rogers

Este artigo sublinha o valor actual dos diversos contributos de Carl Rogers, que tiveram início na década de 1940. Promove-se a consciência de que os paradigmas da psicoterapia são construções sociais erguidas sobre valores que reflectem os enviesamentos sócio-culturais dominantes, frequentemente geradores de um diferencial de poder excessivo entre terapeuta e cliente. Os terapeutas da abordagem centrada na pessoa e das psicoterapias experiénciais são incentivados a contribuírem para o debate alargado referente às profissões de ajuda e a aproveitarem as oportunidades que lhes são oferecidas pelo campo em crescimento da promoção da saúde, o qual se enraiza numa perspectiva centrada na pessoa e centrada na comunidade.

「関係のポリティクス：カール・ロジャースの貢献?」

本論文では、1940年代に始まった、カール・ロジャースの貢献が現代においてどのような価値を持つのかについて論考する。ロジャースの貢献の一つは、心理療法のパラダイムが、その時代に優勢な社会文化的バイアスを反映し、特定の価値観に基づいた社会的構造であり、そのことがしばしばセラピストとクライアントの間に大きなパワーの違いを生み出していることへの気づきを促すことである。PCAおよび体験過程療法の実践者は、援助職に関するより大きな視点からの対話に貢献し、個人—人間—コミュニティ中心の視点に立ち、発展めざましい健康増進の分野が提示している機会を活用することが望まれる。

L'Uso del Potere nelle Relazioni di Aiuto: I contributi di Carl Rogers

In questo scritto si sottolinea l'attualità ed il valore dei contributi di Carl Rogers. Si concettualizza l'importanza della consapevolezza derivante dal considerare gli approcci psicoterapeutici come costruzioni sociali portatrici di valori che riflettono pregiudizi socioculturali e che spesso creano tra psicoterapeuta e cliente eccessivi differenziali di potere. Gli esponenti delle psicoterapie centrate sulla persona ed esperienziali sono incoraggiati ad impegnarsi attivamente nell'odierno dibattito concernente le relazioni di aiuto nonché nel dare un maggiore contributo alla crescita del campo della promozione della salute, un campo caratterizzato dall'essere centrato sulla persone e sulle comunità.

The 40s saw the start of Rogers' revolutionary contribution to the field of psychotherapy. His theories helped to democratize the role of the psychotherapist by challenging the authoritarianism that was pervasive at the time in the helping professions (Farson, 1974). He challenged therapists to ask themselves if they were aware of the "social construction" they were actively creating with their clients (at the time labeled as "patients") – to ask themselves if, as helping professionals, they were part of the solution or part of the problem.

To fully grasp the relevance of Rogers' critique of the predominant vision of human nature and of the nature of helping relationships it is necessary to understand

the social constructions of reality that were implied in the psychotherapies of that time. Sigmund Freud (1932/1963, p. 303) wrote that the mind is “to be compared with a modern State in which a mob, eager for enjoyment and destruction, has to be held down forcibly by a prudent superior class.” John Watson (1924, p. 11), the father of behaviorism, stated: “The interest of the behaviorist is more than the interest of a spectator – he wants to control man’s reactions as physical scientists want to control and manipulate the natural phenomena.” That psychotherapy is a political act, and that each paradigm has different built-in politics, is evident in these statements. For Sigmund Freud the purpose was to control and sublimate the volcanic and destructive aspects of human nature. For Watson, the aim was to take control and to correct, with well-intended technocratic zeal, the maladaptive learning of patients.

Those visions of human nature and those etiologies and theories of therapy automatically exclude – and they actually hide – the built-in stressors deriving from the sociocultural system. They focus on the individual in isolation from their environment. In these terms, there is a risk that psychotherapy becomes a form of social control, with the psychotherapist as an agent of the maintenance of the status quo. But what about social injustice, racism, sexism, ageism, homophobia, and other forms of discrimination and violence? Rogers’ vision and aim are quite different. He writes, for instance: “I object to the process of depersonalization and dehumanization of the individual which I see in our culture. I regret that the behavioral sciences seem to me to be promoting and reinforcing this trend” (1968, p. 59).

The politics of therapy

Rogers (1977) was wary of the way he was trained as a student in the biomedical tradition, which offered only pathogenic paradigms. Clinical experience taught him that there was a need for a more democratic, more optimistic approach, respectful of the client’s experience and supportive of their potential for growth and change. He wrote:

In 1940 I began to try to change what I would now call the politics of therapy. Describing an emerging trend, I said, “This newer approach differs from the older one in that it has a genuinely different goal. It aims directly toward the greater independence and integration of the individual rather than hoping that such results will accrue if the counselor assists in solving the problem. The individual and not the problem is the focus. The aim is not to solve one particular problem but to assist the individual to grow, so that he can cope with the present problem and with later problems in a better integrated fashion.” (Rogers, 1977, p. 6)

Rogers (1939, 1942, 1951, 1957, 1959) believed that labeling people in distress as “patients” would contribute to their problems, not to their solutions, since such a socially construed label would disempower them by restricting them to a passive, dependent role. As a healthier, more democratic and more effective alternative, he suggested the use of the term “client” (Rogers, 1942, 1951). He wrote:

We have increasingly used the term client, to the point where we have absorbed it into the label of “client-centered therapy.” It has been chosen because, in spite of its imperfections of dictionary meaning and derivation, it seems to come closer to conveying the picture of the person as we see it ... since it avoids the connotation that he is sick, or the object of an experiment and so on. (Rogers, 1951, p. 7)

Rogers was already expressing ideas that would later be postulated in the sociology of knowledge, which maintains that what we call “reality” is socially defined. In other words, “reality” is a social phenomenon, since our consciousness develops in specific social contexts where specific groups and individuals like priests, politicians, psychotherapists, etc. are recognized as definers of the social reality (Berger & Luckmann, 1966). A person’s self is socially constructed and reconstructed through social interactions (Mead, 1934). People’s identity and behaviors are influenced by the terms or labels used to describe or classify them and so they become stereotyped and live up to what is expected of them. As Becker (1963, p. 9) states: “The deviant is one to whom that label has been successfully applied; deviant behavior is behavior that people so label.”

A different view of human nature

Rogers’ (1942, 1951, 1956, 1957, 1959) vision of the human being had radical implications for psychotherapy. If the human organism can be trusted in its innate capacities for self-awareness and self-regulation, then the purpose of the therapeutic relationship cannot be limited just to reparative interventions. Central to the person-centered approach is a collaborative relationship between professionals and their clients, and a focus on developing potentialities, not just remedial efforts. In *The Clinical Treatment of the Problem Child*, Rogers had already developed a psychotherapy that was based on trust of human nature and was not disease-centered. He (1939, pp. 282–283) wrote: “In psychotherapy the aim is to leave the major responsibilities in the hands of the child as an individual growing towards independence. The more this is and can be done, the more lasting and effective the treatment.” Many years later, Rogers (1977, p. 7) reflected:

From the perspective of politics, power, and control, person-centered therapy is based on a premise which at first seemed risky and uncertain: a view of man as at core a trustworthy organism. This base has over the years been strengthened by experience with troubled individuals, psychotic persons, small intensive groups, students in classes, and staff groups.

Rogers’ vision concerning the innate capacity for growth was not completely new. It was understood that plants and animals had within their nature the innate capacity to develop their full potentiality if the environmental conditions allowed that to fully bloom. However, human beings were treated as though they did not have this capacity. On the same page of his book *On Personal Power* he added:

Biologists, neurophysiologists, and other scientists, including psychologists, have evidence that adds up to one conclusion. There is in every organism, at whatever level, an underlying flow of movement toward constructive fulfillment of its inherent possibilities. There is a natural tendency toward complete development in man. The term that has most often been used for this is the actualizing tendency, and it is present in all living organisms. It is the foundation on which the person-centered approach is built. (Rogers, 1977, p. 7)

Psychotherapy is a political act

Politics, in present-day psychological and social usage, has to do with power and control: with the extent to which persons desire, attempt to obtain, possess, share, or

surrender power and control over others and/or themselves. It has to do with the maneuvers, the strategies and tactics, witting or unwitting, by which such power and control over one's life and others' lives is sought and gained – or shared or relinquished. It has to do with the locus of decision-making power: who makes the decisions that, consciously or unconsciously, regulate or control the thoughts, feelings, or behavior of others or oneself. (Rogers, 1977, p. 4)

Every therapeutic approach is based on a specific vision of human nature which, in turn, is based on values. Those values determine the politics of the helping relationship and influence outcomes. To be trained generally in the biomedical reductionist model, or to be trained specifically as a psychiatrist, Freudian analyst, behaviorist or person-centered psychotherapist, is to enter into and belong to a constructed world of values, to take on different roles, and to create clinical settings that actively promote different narratives. Different therapeutic approaches espouse different definitions of human nature, disease, illness and cure, of the roles of therapist and recipient of the service provided (Foucault, 1971, 1976, 1977, 1980; Gergen, 1985, 1994; McNamee & Gergen, 1992; Proctor, 2002; Zucconi, 2001, 2008; Zucconi & Howell, 2003).

Given that any view of human nature is based on a set of values, it is, in reality, a political act. Furthermore, every relationship is political, any relational act is political and power dynamics are present and shape them. Psychotherapy has a distinct power dynamic since it is a form of relationship where the recipient usually asks to receive psychotherapy in order to change. The recipient recognizes the socially given authority, power and expertise of the therapist and in order to benefit from the treatment has to renounce her or his way of relating to herself or himself, others and the world. The client needs to develop a new way to construe experience and generate their behavior – in other words, to internalize the psychotherapist and their narrative. Michael Polanyi (1958) has addressed this aspect in terms of the implicit and nonconscious interpersonal learning that we continuously exchange. Psychotherapy relationships are, for these reasons, characterized by a pronounced power differential between the professional and the patient or client (Proctor, 2002, 2004, 2005, 2006; Sanders, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003). This power differential is larger or smaller in different psychotherapeutic approaches: It is larger when the therapist's role is that of an expert who is supposed to diagnose, cure and demand compliance. In the person-centered psychotherapies, where the relationship is based on trust in the person's capacity for self-understanding and self-regulation, the power differential is intended to be much smaller. Here the role of the therapist is not to diagnose and cure but to support the formative tendency of the client, to adopt a phenomenological position that respects and trusts the client's understanding of their experience. "It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried" (Rogers, 1961, pp. 11–12).

Rogers' view was revolutionary in its time but unfortunately it is equally relevant and needed for present-day psychotherapy practice. Some of the current issues and concerns in healthcare and psychotherapy are not so different from those that Rogers and his colleagues grappled with in the 1940s and 1950s: managed care, the manualization of psychotherapy, the politics and values of psychotherapy research, professional regulation, and psychotherapy as social control. We, from the person-centered and experiential (PCE) community, can make a significant contribution today to the discourse and professional politics in the field of helping relationships.

In order to do so effectively we need to continue in the footsteps of Rogers to address and make explicit the issues of values and the use of power in the helping professions. We need to engage actively with efforts to develop socially aware and democratic practice, and we should, on a political level, engage with the themes of emancipation and empowerment.

The biopsychosocial paradigm

Rogers was not alone in proposing an alternative to the disease-centered model imprinted in professional practice. He acknowledges the influence of Otto Rank and Jesse Taft (Rogers & Russell, 2002, p. 113) and refers to the work of others: e.g., Goldstein, Horney, Sullivan, Angyal, Mowrer and Kluckhohn (Rogers, 1951). However, he was the first psychotherapist who developed a *complete* psychotherapeutic holistic/systemic paradigm based on health and centered on the person.

His view of human nature was a drastic departure from the dominant view held at the time by the helping professions, it was different from the biomedical model of allopathic medicine, criticized many years later by Engel (1977, p. 130):

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and the doctrine that separates the mental from the somatic. Here the reductionistic primary principle is physicalistic; that is, it assumes that the language of chemistry and physics will ultimately suffice to explain biological phenomena.

It could be argued that Rogers was a forerunner in the development of a biopsychosocial paradigm. The essential premise of the biopsychosocial paradigm is that health and illness are determined by interrelated biological, psychological and social factors. Somatic health, psychological health, public health and environment are inextricably linked.

Within this socio-ecological approach to health, health professionals then become *agents for social change*, supporting individuals, communities and institutions in weaning themselves from passivity and dependency, empowering themselves to become protagonists in the promotion of their health and wellbeing through identifying and addressing the biopsychosocial determinants.

A person/people/community-centered approach to health promotion

It is not that this approach gives power to the person; it never takes it away. That such a seemingly innocent base can be so truly revolutionary in its implications may seem surprising. (Rogers, 1977, p. xii)

Health is a resource for everyday life. The Ottawa Charter (WHO, 1986) defines health not only in terms of physical capacities, but also in terms of social and

personal resources. Health promotion shifts the focus from diseases and their prevention to increasing health and wellbeing through the promotion of social change. In this process of enabling people to increase control over their health the principal actors are the people and the communities themselves. Health is no longer seen as the absence of illness nor is it the monopoly of the health sector, since health promotion goes beyond health care. It puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

The systemic biopsychosocial paradigm of health promotion bases its strategies on the interactions between people, their behaviors and the environment. This model takes account of:

- the understanding that health is socially construed
- the influence of social and environmental factors as health determinants
- the whole person, in the human ecology context and the influence of this on health and wellbeing
- the importance of human dignity and the development of personal agency
- the importance of personal, family, group and culture constructs in relation to health
- the impact of health and healthy behavior on people's lives
- the importance of the individual in promoting and caring for their health
- the supportive and empowering role of professionals as promoters of change and social justice and equality.

In people-centered approaches to health promotion the role of the professional changes from the expert that gives prescriptions to passive patients to that of a consultant and facilitator of change in a collaborative, empowering relationship. People are not seen as passive patients or as ill or handicapped; they are related to as citizens with inalienable rights, actively protecting and promoting their rights and their health and wellbeing. When the helping professional considers people as able and response-able, they will seek to build a relationship where the aim is not just to treat disease; instead the development of the client's potentialities is promoted by helping the client to increase self-efficacy, initiate behavioral changes, to relate better to themselves and to others, develop agency and their personal and social support systems.

The Person-Centered Approach (PCA) is a systemic, holistic, scientifically validated approach focusing on health instead of illness, on empowerment rather than cures, and promoting the enhancement of the potentialities of individuals, groups and organizations through the process of facilitating and encouraging responsibility. Its values and ethics are congruent with the biopsychosocial paradigm and with the aims and ethos of health promotion (Zucconi, 2001, 2008; Zucconi & Howell, 2003).

The fundamentally radical and revolutionary philosophy of the PCA still has meaning today. The experience of our work in the area of health promotion in Italy has shown us the continuing relevance and power of the approach – not only in therapeutic work with clients, but also through involvement with the development of specific projects for health and wellbeing, through contributing to the education of healthcare professionals and participation in research, and through engagement with political processes and work with the media. I encourage person-centered and

experiential (PCE) practitioners to become more actively engaged in the wider discourse concerning the helping professions and to make a much needed contribution – in particular by taking the opportunities offered by the growing field of health promotion, which is rooted in a person-people-community-centered perspective. Then we will find that empowerment works both ways.

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